Starr Commonwealth

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Name _______________________ Date of Birth _______________

Street Address _______________ City _______________ State _______ Zip _______

I hereby authorize Starr Commonwealth to release/obtain the following information:

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to:

Name of the organization to which disclosure is to be made _______________ Phone _______________

Contact person at this organization to which information is to be sent _______________ Fax _______________

Street Address _______________ City _______________ State _______ Zip _______

This information is to be used for the following purposes:

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I understand that this consent expires in 90 days unless previously revoked by me in writing.

Signature _______________________ Date _______________

Signature of Parent/Guardian if under 18 _______________________ Date _______________

Fax completed form to Starr Commonwealth 517.629.2317 or mail to Records Manager, Starr Commonwealth, 13725 Starr Commonwealth Road, Albion, MI 49224.