

# **ADOPTION INSIGHT INC.**

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## **Consent to Release Information**

I, \_\_\_\_\_, \_\_\_\_\_ hereby authorize the following, but not limited to,  
(Name) (Date of Birth)

Hospital: \_\_\_\_\_

Physician/Clinic: \_\_\_\_\_

Attorneys: \_\_\_\_\_

Agency/Dept. of Social Services: \_\_\_\_\_

Therapist/Counselor: \_\_\_\_\_

Adoption Service Provider (ASP): \_\_\_\_\_

Other: \_\_\_\_\_

To release and reciprocally exchange information regarding my background information, pregnancy, delivery, and adoption plans with each other. Therefore, I am waiving confidentiality regarding my pregnancy and delivery.

This includes but is not limited to, specific authorization to share information regarding my prenatal care, labor and delivery, my risk status, my own condition and/or that of my unborn or newborn infant, my prescription records, my mental health history, and my feelings about the adoption plans. This also includes release of post-birth (but birth-related) lab results, as well as release of the birth certificate and information related thereto.

I also specifically authorize the release of information regarding my use of alcohol and/or drugs, and the results of any tests for the presence of such substances and/or for antibodies to the HIV virus, either in myself, or the child with whom I am now pregnant.

The information for which I authorize release is for use in connection with adoption planning, and it shall not be used for any other purpose. It shall be limited to information relevant to the progress or outcome of this pregnancy.

This authorization shall remain valid for two years from date of execution with the starting date of signature below. A copy of this authorization shall have the same effect as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date