AUTHORIZATION TO RELEASE MEDICALI NFORMATION NCBE Character and Fitness Application Question 31

Applicant's Full Name:					
Date of Birth:So	ocial	Security N	umber:		
Name of physician, counselor, hospital, or institut	tion:				
Address:					
City:	State	/Province:_			
Postal/ZIP Code:Cou	ıntry:				
By signing below, I authorize the above provider to illness or the use of drugs and alcohol concerning a of the Board of Bar Examiners of the Delawar investigation into my moral character, professiona any such information as may be received will be will be used or disclosed at my request. This author signature below. A photocopy of this form is acce. I hereby release, discharge, and exonerate (i) the B its agents and representatives, and (ii) the above na information, from any and all liability of every nat any documents, records, and other information, Examiners of the Delaware Supreme Court. I am not required to sign this authorization in orderight to refuse to sign this authorization. When authorization, it may be subject to redisclosure by the HIPAA Privacy Rule or state law. I have the right that the above provider has acted in reliance upon the significance of the provider has acted in reliance upon the significance of the provider has acted in reliance upon the significance of the provider has acted in reliance upon the significance of the provider has acted in reliance upon the provider has acted in	advice Solution and solution an	e, care, or trupreme Coutation, and tred only to ion will expect for purpoor of Bar Exard provider and kind aries out of the information ecipient and woke this author	reatment provide urt who are in a fitness to pract the admitting a pire one year from ses of obtaining miners of the Defin dits agents and sing out of the finvestigation may no longer athorization in witzation. My writed the interval of the provided may no longer athorization in witzation.	ed to me, to represent to me, to represent to me, to represent to me, and the date of my, this information of the date of the	esentatives ucting an stand that formation or notarized in. Court and furnishing pection of rd of Bar I have the int to this the federal the extent
resubmitted to the privacy officer at the address of	the a	above provi	der.		
			G: · · · · ·		
STATE OF	,		Signature of	Applicant	
)	SS.			
COUNTY OF)				
SWORN TO AND SUBSCRIBED before me, this	s	day of		, 20:	
My Commission Expires:					
			Notary F	Public	

The Board of Bar Examiners of the Delaware Supreme Court is aware of HIPAA requirements.