DO NOT ALTER THIS FORM

FORM 27B / AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Applicant's Full Name: _____

Date of Birth: _____ Social Security Number: _____

Name of physician, counselor, hospital, or institution: _____

_____

Address: _____

City: _____ State/Province: _____

Postal/ZIP Code: _____ Country: _____

By signing below, I authorize the above provider to provide information, without limitation, relating to mental illness or the use of drugs and alcohol concerning advice, care, or treatment provided to me, to representatives of the Board of Bar Examiners of the Delaware Supreme Court who are involved in conducting an investigation into my moral character, professional reputation, and fitness to practice law. I understand that any such information as may be received will be reported only to the admitting authority. The information will be used or disclosed at my request. This authorization will expire one year from the date of my notarized signature below. A photocopy of this form is acceptable for purposes of obtaining this information.

I hereby release, discharge, and exonerate (i) the Board of Bar Examiners of the Delaware Supreme Court and its agents and representatives, and (ii) the above named provider and its agents and representatives furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of any documents, records, and other information, or out of the investigation made by the Board of Bar Examiners of the Delaware Supreme Court.

I am not required to sign this authorization in order to receive treatment from the above provider. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or state law. I have the right to revoke this authorization in writing except to the extent that the above provider has acted in reliance upon this authorization. My written revocation must be resubmitted to the privacy officer at the address of the above provider.

_____
Signature of Applicant

STATE OF _____)
) ss.
COUNTY OF _____)

SWORN TO AND SUBSCRIBED before me, this _____ day of _____, 20___:

My Commission Expires: _____ _____
Notary Public

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