

DO NOT ALTER THIS FORM  
Corrections/erasures  
VOID this form Please  
use black or blue ink

To be used with Question 10

### FORM 7B / AUTHORIZATION TO RELEASE MEDICAL INFORMATION

*Applicant's name* \_\_\_\_\_

*Name of institution, doctor, or counselor* \_\_\_\_\_

*Address* \_\_\_\_\_

*City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

*Country* \_\_\_\_\_ *Provence* \_\_\_\_\_

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 National Conference of Bar Examiners, the Supreme Court of Ohio, the Board of Commissioners on Character and Fitness of the Supreme Court of Ohio, and the Office of Bar Admissions of the Supreme Court of Ohio who are involved in conducting an investigation into my moral character, professional reputation, and fitness for the practice of 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 the National Conference of Bar Examiners, its agents and representatives, the Supreme Court of Ohio, its agents and representatives, and the above named provider, its agents and representatives so 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 National Conference of Bar Examiners or by the Supreme Court of Ohio.

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. I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be resubmitted to the privacy officer at the address of the provider above.

\_\_\_\_\_  
*Signature of Applicant*

STATE/DISTRICT OF \_\_\_\_\_

COUNTY/PARISH OF \_\_\_\_\_

Subscribed and sworn to or affirmed before me this \_\_\_\_\_ day

of \_\_\_\_\_ , \_\_\_\_\_

*Month*

*Year*

\_\_\_\_\_  
*Signature of Notary Public*

My commission expires \_\_\_\_\_

Seal or stamp must be affixed to each original.

The Supreme Court of Ohio is aware of HIPAA requirements.