Mental Wellness 360

AUTHORIZATION TO RELEASE INFORMATION

I/we _____hereby authorize

_____of Mental Wellness 360 to release confidential information to the following individual(s) and to obtain confidential information from them. Please provide their name, title, and phone number.

_____

_____

Please state the reason for this release and the type and extent of information you wish disclosed.

_____

_____

_____

Identify any information that you do not wish to be released.

_____

_____

I understand that I can revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my expressed revocation, this authorization will automatically expire on _____ or under the following conditions

_____

_____

_____

Please print name here

_____ _____

Signature Date

_____ _____

Suzy Anderson, MA., LPC Intern Date

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