Family Solutions & Wellness Center

Authorization to Release Information

Client Name: _____ Date of Birth: _____

I request and authorize Family Solutions & Wellness Center, PLLC to release and exchange information to:

Name: _____

Address: _____

_____

Phone: _____

This request and authorization applies to:

__ All mental health and client information (including diagnosis, treatment plan, demographic information, and insurance information)

__ Other: _____

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Therapist/Witness Signature Date

THIS AUTHORAIZATION REMAINS IN EFFECT UNTIL TREATMENT IS COMPLETED OR I DECIDE TO REVOKE THE RELEASE. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.