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AUTHORIZATION TO RELEASE CLIENT RECORDS & INFORMATION

I (client/designee name) _____, hereby authorize Whole Mental Wellness to send and receive (what is to be released?):

_____

RELEASE TO/FROM:

NAME: _____

ADDRESS: _____

_____

PHONE #: _____

RELATIONSHIP TO CLIENT: _____

PURPOSE OR RELEASE: **Continuity of Care**

CLIENT/DESIGNEE SIGNATURE: _____ DATE: _____

PRATITIONER SIGNATURE: _____ DATE: _____

I understand that I may revoke this authorization at any time by notifying this organization in writing, and it will be effective on the date notified to the extent action has already been taken in reliance upon it.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Privacy Regulations.
I understand that this release will be for up to one year of the date below, unless written consent is given to this organization.

OFFICE USE ONLY

Release Sent :_____**By(staff initials): _____ Date: _____**