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CONSENT TO RELEASE INFORMATION

THIS DOCUMENT PROVIDES THE AUTHORIZATION FOR THE RELEASE OF INFORMATION AND/OR THE REQUEST FOR INFORMATION AS INDICATED BELOW.

_____ _____

Client Name DOB

_____

Client Address City State Zip

I, the undersigned, authorize _____ and Cascade Center for Wellness to receive information from / send information to:

Agency/Individual: _____

Address: _____

Phone: _____

As indicated below, this authorization for release of information extends to care and treatment of the client received during:

___ Services between _____ and _____

___All dates of service

This information may be used for the following purposes:

___ Evaluation, assessment/treatment

___Ongoing coordination of treatment

___ Other: _____

The information to be released is:

___Medical Evaluations

___ Test Results

___ Hospital Discharge Summary

___ Other: _____

___ Treatment Plan/Summary

___ Psychosocial History

___ Psychological evaluation

This written consent is subject to revocation by the undersigned at any time, except when action has been taken in reliance hereon. If not earlier revoked, or by another agreement specified below, this consent shall expire:

___ 90 days from date signed

___ 1 year from date signed

___ 6 months from date signed

___ Other: _____

_____ _____

Signature of Client/Parent/Legal Guardian Date

_____ _____

Witness Date