

RELEASE

I hereby give my permission for: _____
Name of Agency, hospital, therapist, etc.

Street Address

City State Zip

To release or disclose to: _____
Name or title of person or organization

Street Address

City State Zip

The information to be disclosed is limited to: _____

The purpose or need for disclosure is: _____

The information concerns the care given to: _____
Client name

This consent is subject to revocation at any time in the form of written notice from myself, except to the extent that action has been taken in reliance thereon, or without revocation, will expire one year from the date signed below.

Signed _____ Date _____
Client or legal representative

Relationship (if other than client) _____ Date _____

Witness _____ Date _____