Whole Health Nutrition, LLC

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CONSENT FOR RELEASE OF INFORMATION

I, _____ (_____) authorize
(name of client) (date of birth)

to _____ to
(name of clinician)

receive information from: disclose information to:

Name/entity: _____ Phone:_____
Address: _____
Name/entity: _____ Phone: _____
Address: _____
Name/entity: _____ Phone: _____
Address: _____

Specific Information to be disclosed is:

All pertinent information may be disclosed (this may include some or all of the items listed below).

Or, if you'd prefer to specify what types of information may be disclosed, you may indicate the categories of information you consent to have disclosed below:

Assessment/diagnostic results/information
Treatment Plans and Recommendations
Social and Personal History
History of Mental Health Treatment
Medical History and Medical Records
Other: _____

History of Any Substance Use/Dependency
Reports/Discharge Summaries from Other Facilities
Psychotherapy Notes

I understand that this information will not be given to anyone else without my written consent. I also understand that I may revoke this consent for release of information at any time unless action based upon this authorization has already occurred. I also understand that unless I revoke this consent form, it will be in effect until I am no longer receiving services at WHN unless I indicate an earlier date here: Date: ___/___/_____.

Signature of Client: _____ Date: _____
Or legally authorized representative's signature:_____ Date: _____
Representative's relationship to Client (parent, guardian, etc.) _____