Whole Mental Wellness
Psychotherapy and Medication Management

wholementalwellness.com
100 Clinton St., Fayetteville, NY 13066
315.218.5909 Fax: 253.660.7383

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 for Release: Continuity of Care

Client/Designee Signature _____________________________________ Date: ______________
Practitioner 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 maybe subject to r e-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.

Official Use Only

Release Sent: _____________________ By (staff initials); __________ Date: ______________