Holistic Behavioral Health, LLC

# *Clinical Services & Wellness Center*

**Authorization to Release Information**

I, _____, DOB: _____ hereby authorize Holistic Behavioral Health LLC and my practitioner _____ to exchange clinical and/or nutrition information and records obtained in the course of my diagnosis and/or treatment with_____

This exchange of information and records authorized herein is required for the following purpose(s):

Coordination of care/treatment

Coordination/allocation of benefits

Sharing of information

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This consent is subject to revocation by the undersigned at any time except to the extent that action has already been take in reliance hereon. If not earlier revoked, this authorization shall terminate one year from the date it was signed.

I have carefully read and I understand the foregoing information. I consent to the release of the above-specified clinical information for the purposes listed above. I further release Holistic Behavioral LLC and the practitioner noted above from any liability incurred from the release or exchange of this information to the above designated persons or agencies.

_____

Signature of Client Date

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Signature of authorized and/or responsible individual/guardian Date

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Signature of Staff Date