The Vine Wellness Group

REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION

OUTSIDE ORGANIZATION OR INDIVIDUAL

Name _____

Address _____

Phone # _____ FAX: _____

CLIENT INFORMATION

Client/s Name _____ Date of Birth _____

Parent's Name (if minor client)

_____

Address _____

Specific information to be released and purpose for which information is needed:

_____

_____

_____

Types of Release Granted:

___ ONLY FROM _____, LPC or LPC-Intern TO the Outside Organization /Individual

___ ONLY TO _____, LPC or LPC-Intern FROM the Outside Organization /Individual

___ BETWEEN _____, AND the Outside Organization /Individual

I fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the possible implications of their release. This request is voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. Revocation of consent must be submitted in writing. The Vine Wellness Group, Annie Viers MA, LMFT, LPC-S, Celeste R. Inman, M.ED., LPC-S, RPT and LPC-Interns are not responsible for confidential information which is passed on to any party not named in this release.

Client Signature: _____ Date _____

Printed Name _____

Parent / Legal Guardian Signature (for Minors) _____Date_____

Witness Signature _____ Date _____

Witness Printed Name _____