Gainesville Healing House, Inc.
352-660-4142

Consent to Release Information

Client Name: _____ Date of Birth: _____

I give permission to Gainesville Healing House, Inc. to release any relevant professional information about me including, but not limited to diagnoses, treatment plan and clinical impressions to _____. I understand that information will be released with respect and will be used to benefit my overall care.

I also authorize _____ to release relevant information about me, including, but not limited to diagnoses, treatment plan, and clinical impressions to Gainesville Healing House, Inc.

Exceptions to this authorization include: _____

_____

_____

I consent to the disclosure of the above information to those person(s) and/or institutions named above. I understand that I may revoke this consent at any time and that it will remain in place, indefinitely unless I revoke it. I release both parties from any legal action pertaining to releasing information.

_____ _____
Client Signature Date

_____
Relationship to client if a minor