Authorization to Release Information

Clients Name: _______________________________ Date of Birth: _____________

I authorize Dragonfly Wellness and Education Center to:

- ☐ obtain from
- ☐ release to

Name: ______________________ Address:________________________ the following documents from the records pertaining to services received from:

- ☐ __________ to _____________ OR
- ☐ all past, present, and future periods.

The documents to be released are described or listed as:

- ☐ Identifying information
- ☐ Intake / Evaluation / Diagnostic Summaries
- ☐ Discharge / Exit Summary
- ☐ Treatment plan and/or progress notes
- ☐ Scheduling / attendance

The records are required for the specific purpose of:

- ☐ Continuing care / Consultation
- ☐ Sharing and exchange information with above mentioned persons for the purpose of providing assistance to my treatment.

I understand that my authorization will remain effective from the date of my signature until, ____/____/_____, and that the information will be handled confidentially in compliance with all applicable federal laws. I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

____ _______________

Signature of Consumer/ Consumer's Designated Representative Date

____ _______________

Witness Date