Full Circle Counseling & Wellness

828.222.0401 *phone*

888.595.9450 *fax*

www.fullcirclewnc.org

RELEASE OF INFORMATION

____
Name

_________________________ _________-_________-__________
Date of Birth SSN

In order to better understand my treatment and to make fully informed decisions, I authorize

____ to release information indicated below
Name of provider(s) releasing information

to ____.
Name of provider(s) receiving information

Please circle information included in this release:

Family History
Employment/Unemployment
Educational Reports
Alcohol/Drug Services

Mental Health Services
Medical/Psychiatric Services
HIV/AIDS
Other: ______________________

I am aware that I am able to cancel this permission at any time, but that will not affect any information released before the cancellation. I understand that I am voluntarily authorizing the release of this confidential information and that I have the legal ability to sign as:

(Please circle one)

Client *Parent* *Guardian* *Legal Power of Attorney*

____________________________________ ___________________
Signature Date

____________________________________ ___________________
Witness Signature Date