Capstone Wellness Center

AUTHORIZATION TO REQUEST OR RELEASE INFORMATION

Client's Name:

Client's Address:

Date of Birth (day/month/year):

I hereby authorize the following designated office or person of [Capstone Wellness Center] to release or request the following personal information about me:

___Request verbal report(s) from: _____

___Request written report(s) from: _____

___Release verbal information to: _____

___Release written information to: _____
(agency, organization, school, hospital, professional, etc.)

The following information:

For the purpose of (specify):

This authorization can be terminated at any time in writing.
This authorization is valid for the duration of involvement, up to one year

Signed:_____ _____ _____
(Client 12 years of age and older) Date Witness

Signed:_____ _____ _____
(Parent or legal guardian) Date Witness