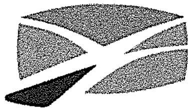

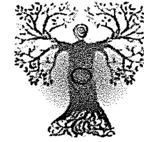

Release of Information

Date:__________________________

Name:	Phone:	Cell:
Address:	DOB/Age:	
City/State:	Zip:	County:
Email:		

I hereby authorize Benjamin Deeb of Healing Springs: -

Name:	Phone:	Other:
Address:	City/State:	
	Zip:	County:
Email:		

To Release and Receive Information To:

Name:	Phone:	Other:
Address:	City/State:	
	Zip:	County:
Email:		
The following information is requested:		
Authorization to disclose information is effective until: (Date)		

Consent:

This authorization is voluntary and remains in effect until the above date or 1 year from date, unless specifically revoked by written notice to the agency or person. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy/scanned copy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form of medium, including oral, written or electronic.

Signature:____ Date:_______________________