



Authorization for Release of Information

Client Information

Client Name: _____

Birth Date: _____

Authorization

I authorize Topaz Wellness to disclose, release, and/or receive information to/from (circle one):

Name/Agency: _____

Relation to Client: _____

Address: _____

Telephone: _____

Information to be Released

Limits of Release: _____

Conditions of Release: I understand that my signature authorizes the release of this information only between the above named persons or agency. This information may not be made available to others who request it secondarily and will not be re-released to any other person or agency. I understand that except to the extent that action has been taken on my authorization, I may withdraw this authorization at any time by written notification. I understand that this authorization shall remain in effect for ninety (90) days from the date on my signature below, unless I specify an earlier expiration date in this space:

Signature of Legal Guardian

Signature of Witness

Date

Date