Authorization for External Release of Information

I, _____, hereby authorize the release of information and communication between the tenants and professionals affiliated with TRU Integrative Health and Wellness, LLC and:

_____

_____

_____

The information released and shared will be for the purpose of:

_____

I would like to authorize the above parties to release and communicate about my medical and/or mental health information within the below limitations:

_____

_____

By signing this document, I indicate my full understanding that my authorization is optional, that treatment is not conditioned upon the signing of this document, and that I have the right to refuse to sign this document. I also understand that this Release of Information is in effect for the period of time necessary to facilitate comprehensive collaborative care, and that I can revoke or change this authorization in writing at any time, unless TRU Integrative Health and Wellness, LLC and it's tenets and affiliated professionals have taken action in reliance upon it. I understand that if I wish to change or revoke authorization, such changes or revocation must be received in writing at 3116 Maple Drive, Atlanta, GA 30305. Any disclosure of information extended beyond these designated parties is considered a breach of confidentiality. I understand that I have the right to receive a copy of this document upon request.

_____

Client/Patient Signature Date

_____

Parent/Legal Guardian Signature Date