Feller Behavioral Health

Helping Individuals, Couples and Families Put The Pieces Together

Release of Information

Name:_____Birthdate: _____/_____/_____

Address: _____City_____State_____Zip_____

o I Authorize Feller Behavioral Health Services to ***release*** information to:

_____
Name of Individual, Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/ Fax # (include area Code)

I understand that authorization shall remain valid from the date of my signature below and until I am no longer receiving services from Feller Behavioral Health.

I have been informed that I may revoke this authorization by written or oral communication to Feller Behavioral Health Services. I certify that this form has been full explained to me and that I understand its contents.

_____ _____
Print Name Date

_____
Signature of Client

_____
Signature of Parent or Guardian (if client is under 18)

_____ _____
Signature of Witness Date

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