Feller Behavioral Health

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For more information - FellerBehavioralHealth.com

Helping Individuals, Couples and Families Put the Pieces Together

RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

☐ I authorize Feller Behavioral Health Services to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

AND/OR

☐ I authorize Feller Behavioral Health Services to obtain information from:

_____
Name of 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 Services.

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 fully explained to me and that I understand its contents.

_____ _____
Signature of Client Date of Authorization

_____
Signature of parent or guardian (if client is under 18)

_____ _____
Signature of Witness Date