BALBODHI WELLNESS
COUNSELLING & PSYCHOTHERAPY

CONSENT TO RELEASE PERSONAL HEALTH INFORMATION

I _____, born _____
PATIENT FIRST & LAST NAME *DATE OF BIRTH (MM/DD/YYYY)*

residing at _____
ADDRESS

authorize _____, _____
FIRST & LAST NAME *PROFESSION/RELATIONSHIP TO PATIENT*

working/residing at _____
ADDRESS

to disclose and discuss my personal health information consisting of:

NATURE OF INFORMATION TO BE DISCLOSED

with _____, _____
FIRST & LAST NAME *PROFESSION/RELATIONSHIP TO PATIENT*

working/residing at _____
ADDRESS

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

Print Name: _____ Date: _____

Signature: _____

Britney Avery, MSW britney@balbodhiwell.com **Tel: 519-709-3942 Fax: 1-855-509-0193**