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daringsoulcare.com

awake
●
brave
●
connected

AUTHORIZATION TO RELEASE INFORMATION

____, born on _______________,
(Full Name; please print) (Month/Date/Year)

requests and authorizes:

____,

who is employed by Debbie Miller, LLC/Daring Soul Care, to disclose/obtain information related to my case, including the results of examinations and evaluations, as well as diagnosis and treatment, to/from the following:

Name: ____

Title: ____

Agency: ____

Address: ____

City: ____ State: _____________

Zip Code: ______________________

Phone: ________________________________ Fax: _____________________________

Email: ____

I am aware that all information I hereby authorize to be obtained from this person or agency will be held strictly confidential within the limits of the law and cannot be released by the recipient without my written consent.

I understand that unless otherwise limited by state or federal laws and regulations, and except to the extent that action has to be taken on my consent, I may withdraw this consent in writing at any time.

Signed: ____ Date: ___________

Parent/Guardian: ____ Date: ___________

Witnessed: ____ Date: ___________

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