

Harmony Heals, Inc



Release of Information Authorization

I hereby authorize _____ to release medical, psychiatric, psychological, educational or social information to _____ of Harmony Heals, Inc.

Client Name

Date of Birth

Street Address

City, State, & Zip

Signature

Today's Date

Effective Until

I hereby authorize Harmony Heals, Inc to release medical, psychiatric, educational or social information to the following:

To: _____

Client Name

Date of Birth

Street Address

City, State & Zip

Signature

Today's Date

Effective Until

