



WINDHORSE
INTEGRATIVE MENTAL HEALTH

Windhorse Integrative Mental Health
www.windhorseimh.org

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____ Date of Birth: _____

This is to authorize: _____

(Address)

to disclose and release any information, including psychiatric and psychological records, of the above captioned individual to **Windhorse Integrative Mental Health** who is/are authorized to discuss all matters pertinent to the progress of the client.

This information is considered instrumental to the ongoing evaluation and treatment of this client.

Data Requested:

- | | |
|-------------------------------|------------------------------|
| _____ Psychiatric information | _____ Social welfare data |
| _____ Psychological testing | _____ Rehabilitation records |
| _____ Educational records | _____ Legal information |
| _____ Medical information | _____ other: _____ |

Date _____ Signature _____
(Patient or legal guardian)

(Relationship to client)

(Witness)

Windhorse Integrative Mental Health

NORTHAMPTON Location
211 North St
Northampton, MA 01060
Office: 413-586-0207
Fax: 413-585-1521

SAN LUIS OBISPO Location
1411 Marsh St., Suite 103
San Luis Obispo, CA 93401
Office: 805-548-8931
Fax: 805-548-8930

PORTLAND Location
2120 SW Jefferson St., Ste 300
Portland, OR 97201
Office: 503-290-3421
Fax: 503-290-3618