WINDHORSE
INTEGRATIVE MENTAL HEALTH

# AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____ Date of Birth: _____

This is to authorize: _____

_____
(Address)

_____
(Phone) (FAX#) (email, if applicable)

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

_____ Psychological testing

_____ Educational records

_____ Medical information

_____ Social welfare data

_____ Rehabilitation records

_____ Legal information

_____ other: _____

Date _____ Signature _____
(Patient or legal guardian)

_____
(Relationship to client)

_____
(Witness)

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**www.WindhorseIMH.org**

**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