Zephyr Wellness

An Innovative and Philanthropic Mental Health Practice

Health Information Release Authorization

Client Name: _____
Last Name First Name M.I.

Birth Date: _____

Address: _____
Street City State Zip

Phone: __(____)_____

I authorize Zephyr Wellness to:
_____ **Obtain** my health/mental health/other information from:
_____ **Release** my health/mental health/other information to:

Name: _____
Person or Agency

Address: _____
Street City State Zip

Phone:_____ Email: _____ FAX: _____

This release will expire at 90 days following the last therapeutic contact or with specific written notification. I further understand that Zephyr Wellness staff will not correspond with anyone, authorized or not, about any of my clinical matters unless a reasonably clear clinically relevant need to do so exists.

Guardian printed name: _____ Date: _____

Guardian signature: _____

Client printed name: _____ Date: _____

Client signature: _____

Client printed name: _____ Date: _____

Client signature: _____