Authorization to Release Information

Fredericksburg Relationship Center, LLC

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I, _____, the undersigned, give my permission to release my treatment information to:

_____
(Name)

_____
(Address)

_____
(Phone Number)

Provide the following information (check all that apply)

- ☐ my attendance in therapy
- ☐ my diagnosis
- ☐ my treatment plan
- ☐ information relevant to coordinating care
- ☐ a summary of treatment
- ☐ other (please explain in detail) _____

I understand this release is valid for 180 days. I further understand I may revoke this authorization at any time in writing. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

_____ _____/____/_____
Signature Date