

Patient Information Release

Name:	
Birth Date:	

I authorize the exchange of information between _____ and the following (please initial all that apply):

1. Inits: ____	Referring or Primary Care Physician	Physician Name:
		Practice Name:
		Office Phone:
2. Inits: ____	Health Insurance provider	Name:
		Office Phone:
3. Inits: ____	Other (please specify name, organization):	Name:
		Organization:
		Office Phone:
Extent of information to be released includes:		

This authorization is only for the limited purpose of exchanging information pertaining to my evaluation and treatment with these individuals or companies. It shall not be considered a blanket waiver of all privileged and confidential information. This consent will be in effect for two years from the last date of service unless it is revoked in writing prior to that time. I understand that I may revoke this consent by submitting a written statement to Awakenings Center for Intimacy and Sexuality.

This authorization is fully understood and is voluntarily made on my part.

Patient's, Parent's, or Legally-appointed representative's signature:

Signature	Date

Witnessed by:

Signature	Date