Tranquil Minds
Behavioral Health
Heather M. Gibbon, LLC

Authorization for Release of Information

Client Name: _____

I, _____ (DOB) _____, give consent for any agent of
(client or parent/guardian printed name)

Heather M. Gibbon, LLC dba Tranquil Minds Behavioral Health to do the following:

_____Communicate Verbally With
_____Release Records To
_____Obtain Records From
_____Other Information as Indicated:_____

Name of Person or Business:_____

Address (if needed):_____

Telephone # (if needed) :(____) _____ - _____ Fax # (if needed) :(____) _____ - _____

This authorization will be utilized to: _____ Provide Continuity of Care
_____ Provide Information for a Legal Matter
_____ Other Actions as Indicated:_____

I agree that I have read and signed the Consent for Treatment and Limits of Liability which includes a section explaining Limits of Confidentiality. I agree that prior to signing this authorization I was informed regarding procedures for releasing information and withdrawing consent.

This authorization will be in effect from _____ until _____.

_____ _____
Signature of Client or parent/guardian if under age 14 Date

_____ _____
Signature of Witness Date

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