Whole Health Counseling LLC

Angela Tennis LPC & Suzanne Fortnum LPC

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

I, the undersigned, hereby authorize Whole Health Counseling LLC to obtain/release information pertaining to my evaluation and/or treatment to/from:

Name: _____

Relationship: _____

Address: _____

_____

Phone: _____Email:_____

I authorize the release of the information described above for the following purposes:

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke this authorization at any time; any cancellation or modification of this authorization must be made in writing, and can be sent to: Whole Health Counseling LLC 600 Cameron St. Suite 113 Alexandria, VA 22314.

This authorization shall become effective immediately and shall remain in effect until _____ ("Expiration Date").

Client Name (please print): _____

Signature: _____Date: _____