FAMILY BEHAVIORAL
HEALTH NETWORK, LLC

Family Behavioral Health Network, LLC
221 W. Main ~ Medford, OR 97501
541-821-9559 (Phone) ~541-702-1236 (Fax)

Authorization to Release Information

Name:_____ Date of Birth:_____

I authorize Henderson Behavioral Health, LLC and its affiliate providers, to disclose information to and obtain information from:

Name: _____
Clinic/Agency:_____
Address:_____
Phone:_____

Description of information to be disclosed: _____
_____
_____

The purpose of this is to aid evaluation, treatment, coordination of services and/or other activities (specify): on behalf of the client. I understand that I may revoke this release at any time by submitting a written notification, but that such a request will not apply to any information exchanged prior to the date of such a notification being received by Family Behavioral Health Network, LLC.

Unless sooner revoked, this consent expires on _____or as otherwise indicated.

Signature of Patient/ Legal Guardian _____ Date: _____

Signature of Therapist: _____ Date: _____