Release of Information

I hereby authorize: Veronica Johnson, PMHNP of Moonflower Psychiatry

To:
- Release information to:
- Obtain information from:
- Exchange information with:

Name: ________________________________
Address: ________________________________
____
____
Telephone: ________________________________

This authorization is valid until _____________. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the provider above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my provider has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

____________________________________ ____________________
Patients Name Date of Birth

____________________________________ ____________________
Patients Signature Date

____________________________________ ____________________
Guardian's Signature (if patient is a minor) Date

For blooming in the darkness:

120 Greenwich Rd. Charlotte, NC 28211 | 828-239-9933 | moonflowerpsychiatry.com