Patient Release of information

Patient's Name_____ Date of birth: _____

I hereby authorize and request: *JON SOILEAU, M.A., PLPC, LPC, NCC*

to release to (or) to obtain from

Person/facility:_____

Street address: _____

City: _____ State: _____ Zip:_____

The following information:

_____
_____
_____
_____
_____

Reason information is requested:

_____
_____
_____
_____
_____

Jon soileau will only release information that originates in his office. Consent may be revoked in writing at any time prior to action having been taken. Consent expires one year from the date signed.

Patient Signature:_____Date:_____

Parent/Guardian Signature:_____Date:_____

Witness Signature:_____Date:_____

Jon Soileau M.A., PLPC, LPC, NCC
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Serenitylife.org/Jon-Soileau ▪ 8 1 6.8 9 5.2 5 1 5 ▪ Soileau.Therapy@gmail.com