

PATIENT RELEASE OF INFORMATION

PATIENT'S NAME _____ DATE OF BIRTH: _____

I HEREBY AUTHORIZE AND REQUEST: DANIELLE D. SOILEAU, MA, CIT, NCC

TO RELEASE TO (OR) TO OBTAIN FROM

PERSON/FACILITY: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

THE FOLLOWING INFORMATION:

REASON INFORMATION IS REQUESTED:

DANIELLE D. 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: _____