Peaces 'n PuzSouls
Journies thru Healing

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Authorization to Release Information

The undersigned, _____**,** hereby authorizes Peaces 'n PuzSouls or nay of its authorized representatives, agents and employees, bearing this Release or a copy thereof, to obtain any information in your files, pertaining to the undersigned and his/her medical records, psychological/psychiatric records, educational records and any other said records specified here:_____.

The undersigned voluntarily consents to the release of such information upon request of the bearer from said

Agency: _____

Contact Person: _____ **Email:** _____

Phone: _____ **Address:** _____

The undersigned directs you to release and exchange such information upon request of the bearer made within sixty (60 days) from the date hereof. This Release is executed with full knowledge and understanding that the information hereby requested and obtained is for use by the Agency, in connection with the possible *diagnosis and treatment* of the undersigned by said **Agency:** ***Peaces 'n PuzSouls: Sheila Sweeney, MSW, LICSW, 777 Selby Avenue, St. Paul, MN 55104, (651)797-4094.***

The undersigned hereby releases you, as custodian of such records: hospital or other repository of medical/psychiatric/psychological; educational; social service; criminal justice; any employer or business establishment including its officers, employees or related personnel both individually and collectively; and the Agency, its representatives, agents and employees from any and all liability for damages of whatever kind which may at any time result to the undersigned, his/her heirs, family or associates because of compliance with this authorization and request for information or any other attempt to comply with it. This authorization also consents the above said agencies to communicate via telephone, facsimile, and confidential electronic submissions. *Client has the right to revoke this authorization at any given time by sending written notification to:* ***Peaces 'n PuzSouls: Sheila Sweeney, 777 Selby Avenue, St. Paul, MN 55104.***

The information hereby obtained by Peaces 'n PuzSouls, is to be used only for the purposes of *diagnosis and treatment* of the undersigned by said Agency and may be made a part of the permanent record of the undersigned upon such date of *diagnosis and treatment*. I acknowledge receipt of a copy of this authorization.

_____ _____ _____
Signature of Client Birthdate (mm/dd/yr) Date

_____ _____
Full Name of Client Authorization Expires 1 Year from Date Signed