Wellspring Center, PLLC
1995 NC Hwy 172 Suite B
Sneads Ferry, NC 28460
Phone: 910-327-0800
Fax: 888-728-0060

I hereby give permission for: Wellspring Center, PLLC
1995 NC Hwy 172 Suite B
Sneads Ferry, NC 28460
Phone: 910-327-0800
Fax: 888-728-0060

TO RELEASE HEALTHCARE INFORMATION TO:

Name: _____ Agency: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Initial: __ ☐ Healthcare information relating to the following treatment, condition, or dates:

_____

_____

Initial: __ ☐ All healthcare information

Initial: __ ☐ Other: _____

The purpose for the release of this information is:

_____

_____

By my signature, I authorize the release of any records regarding mental health treatment from Wellspring Center, PLLC, as listed above.

Guardian's Name: _____

Patient's Name: _____ DOB: _____

Address: _____

Social Security Number: _____-____-_____

I understand that the information to be released is protected under state and federal laws and cannot be redisclosed without my further written consent unless otherwise provided for by state or federal law. I understand that I may revoke this authorization at any time, except to the extent that the action has already been taken to comply with it. Without my expression of revocation, this consent will automatically expire in 365 days from the date that it is signed.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____