Authorization to Obtain and Release Confidential Information for the Purpose of Assessment and Future Treatment

I, **(Client name, Parent or Guardian)** ____, hereby authorize Anne Till Consulting LLC to

obtain and release information regarding past and current treatment for **(Client name)**____
to and from the following listed below. This information may include full health history, general and specific information regarding: nutritional, lifestyle, medical and/or psychological or social assessment/evaluation/counselling/treatment and progress notes, laboratory tests, growth charts, special evaluations/testing, diet prescriptions and provided dietary and lifestyle guidelines, school performance, social and emotional functioning, special learning problems or capabilities, educational testing, etc.

Please provide the contact information for your current and/or past therapist, physician, specialist, psychiatrist, nutritionist, treatment center, coach, school/university personnel and any family members with whom you choose to have Anne Till Consulting LLC communicate as part of your treatment team.

Title and Name	Relationship	**Title and Name**	Relationship
Address:		Address:	
City	Zip Code	City	Zip Code
Phone Number Number	Fax	Phone Number Number	Fax
Email	Website	Email	Website

Title and Name	Relationship	**Title and Name**	Relationship
Address:		Address:	
City	Zip Code	City	Zip Code
Phone Number Number	Fax	Phone Number Number	Fax
Email	Website	Email	Website

Title and Name	Relationship	Title and Name	Relationship
Address:		Address:	
City	Zip Code	City	Zip Code
Phone Number Number	Fax	Phone Number Number	Fax
Email	Website	Email	Website

I understand that my records are confidential and will not be disclosed without my consent unless under legal compulsion or in life threatening situations. I also understand that I may revoke consent at any time, providing that the revocation is executed in writing to Anne Till Consulting LLC at 105B Kilmayne Drive , Cary NC 27511. Revocation will not affect any disclosures acting upon by this disclosure and prior to the request for revocation. Information disclosed pursuant to this authorization may be re-disclosed and is no longer protected by federal and state privacy rules. Authorization of disclosure of the above stated information is voluntary and this authorization is not intended to alter the patient's ability to receive medical care from any health care provider. Unless stated, this authorization remains in effect for two years after last consultation with a provider at Anne Till Consulting LLC.

Printed or Typed Name **Date**

Signature / Parent/Guardian Signature if Client is under age 18 **Date**

For online forms click the box above and sign with your finger or mouse. To accept signature, click the "preview signature" button.