INSIGHTFUL DIRECTION
YOUR JOURNEY, YOUR DIRECTION.

RELEASE/REQUEST OF INFORMATION

Patient's Name:_____ D.O.B:_____

I hereby authorize: **Insightful Direction, LLC** to release to, or request from:

_____

_____

_____

The following information from my record (please be specific):

_____

_____

_____

_____

This information is needed for the purpose of:

_____

_____

_____

_____

I understand that the agency abides by Federal Confidentiality Regulations (42 CFR, Part 2) published July 1, 1975, which protect the confidentiality of my records and that information contained in my record cannot be disclosed without consent unless otherwise provided for in the regulations.

I understand that this directive is subject to revocation at any time upon written request. Otherwise, this consent will expire upon one year from date signed,

I herewith release and hold harmless **Insightful Direction, LLC**, from any liability for the release of any information provided in accordance with this directive.

Date Signed:_____

Witness Name:_____Witness Signature:_____

Patient Name:_____ Patient Signature:_____