SOL FLOWER WELLNESS
Wendy E. Crane, Ed.S., LMFT, NCC
200 Waymont Court, Suite 126, #1
Lake Mary, FL 32746
Phone: (407) 739-4267

AUTHORIZATION FOR RELEASE OF INFORMATION

Request and Authorize: *Wendy E. Crane, Ed.S., LMFT, NCC* to RELEASE to and/or OBTAIN from (please circle one):

_____

_____

_____

_____

Regarding (client)_____DOB:_____

Address:_____

_____

I authorize the above named person to release/obtain information either verbally (telephone) or in writing (provide specific information to be used or disclosed):

_____

_____

_____

for the specific purpose of_____.

I understand that this form is not required as a condition for treatment and that it may be revoked by me in writing at any time, except to the extent that action has already been taken. In the absence of revocation, this authorization will expire one year from the date of my signature. A copy of this authorization is as authentic as the original signed Authorization of release. An original will be retained in my mental health record. I fully understand what I just read and acknowledge that I have a right to receive a copy of this "Authorization for Release of Information".

Client Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date:_____

_____ (Client to initial once a copy of form is received)
_____ (Client to initial if a copy is refused)