Disclosure Form/Release of Information

I ____, authorize
Regina A. Orsi- Hoholik CSW,MS,CHT employed by Synergy of Spirit,
to disclose relevant clinical information for the purpose of treatment
planning, and intervention.

Only relevant information is to be shared in collaboration with any psychiatrist, physician, school official, or legal person involved in treating this client/patient.

I have the right to revoke this statement at any time. All information from that time will remain confidential.

____

Signature of Guardian/Patient: Date

____

Clinician: Date