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RELEASE OF INFORMATION FORM

I, _____ , authorize Janelle C. Ettema Ph.D. to obtain and communicate (disclose orally or in writing) information regarding my mental health/substance abuse treatment. This information may include any and all aspects of my treatment as protected under state or federal laws respecting confidentiality of records and communications with health care providers. I authorize communication with the following:

Name(s) of Person(s)/Organization(s):

_____

Address: _____
Street City State Zip Code

Telephone Number: _____

Unless earlier revoked, this authorization is effective for one year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to Dr. Ettema.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date