Primrose Healing and Wellness
405 Primrose Rd.
Burlingame, CA 94010
650-558-1015

Authorization to Release Confidential Information

I, _____ , hereby authorize Primrose Healing and Wellness to release and exchange confidential information obtained during my treatment with _____.

This authorization allows the release of the following information:
____ Diagnosis
____ Treatment Plan
____ Progress to Date
____ Prognosis
____ Clinical Test Results
____ Dates of Treatment
____ Any and All Information Necessary
____ Information for Insurance Purposes
____ Other (please specify): _____

I understand that I am entitled to receive a copy of this Authorization, and that any changes or revocation of this Authorization must be submitted in writing. This Authorization will remain valid for one year from the date signed or as otherwise specified below.

Client's Name: _____

Parent or Guardian (if applicable): _____

Signature _____

Date _____