Bloom Women's Wellness, LLC
10574 Justin Drive, Urbandale, IA 50322
(515) 499-4959 |
contactus@bloomwomenswellness.org

Release of Information

_____ _____
(Client Name) (Client DOB)

I, _____, hereby authorize **Bloom Women's Wellness,** to:

☐ Exchange information with ☐ Receive information from ☐ Disclose information to

_____ _____
(Name of Agency/Person) (Phone)

_____
(Address, Clty, Zip)

Information to be disclosed:

☐ Psychiatric diagnosis ☐ Treatment Summary ☐ Dates of Treatment
☐ Attendance Information ☐ Initial Treatment Plan ☐ Full Treatment Record
☐ Other:

The purpose of disclosure is for:

☐ Treatment Coordination ☐ Diagnosis/Evaluation ☐ Treatment Planning
☐ Education Planning ☐ Other:

This consent is effective from the date of signing and ends on _____ (not to exceed 1 year). I understand that I may revoke consent at any point within this timeframe by written request except when my therapist has already taken action.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (if client under 18) Date

_____ _____
Therapist Signature Date