TRIANGLE
WELLNESS & RECOVERY

CONSENT TO RELEASE RECORDS

I authorize the clinical providers at Triangle Wellness and Recovery PLLC to have a bidirectional exchange of my health records with:

_____

_____

The shared information will be limited to:
(Select at least one)

- ◯ Psychiatric, medical, alcohol, and drug abuse records
- ◯ Psychiatric records only
- ◯ Medical records only
- ◯ Alcohol and drug abuse records only
- ◯ Lab test results
- ◯ Billing
- ◯ Other _____

This consent will be valid until one year from today, or until _____ (Optional end date of consent).

I understand I may receive a copy of this release.

_____ _____ _____
Patient's Name Patient's Date of Birth Date

_____
Patient's or Representative's Signature

_____ _____
Name of Representative if not Patient Representative's Relationship to Patient