4 DIRECTIONS
INTEGRATIVE MENTAL HEALTH, LLC

125 West Boutz
Las Cruces, New Mexico, 88005
575-652-6194

Release of Information

Clients Name:		Client's Date of Birth	/ /

I hereby authorize:	

To:	X	Type of Disclosure	Individual/Provider/Agency
		Release information to:	
		Obtain information from:	
		Exchange information with:	

Address:	
Phone #:	
Fax # or Secure Email Address:	

The information requested or authorized for release or exchange pertains to:

X	Type of Information	Any Limitations
	Mental Health	
	Education	
	HIV/AIDS	
	Sexually transmitted diseases	
	Drug or alcohol abuse	

This authorization is valid for 90 days from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to 4 Directions Integrative Mental Health indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, 4 Directions Integrative Mental Health has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation treatment.

Patient's Printed Name and Signature: _____Date:_____

Guardian's Printed Name and Signature: (if patient is a minor):_____Date:_____

Witness Printed Name and Signature:_____Date:_____