REQUEST FOR INFORMATION

NAME OF PATIENT: _____ DATE OF BIRTH: _____

I, the undersigned hereby authorize the health care provider named below to release records obtained in the course of medical and/or psychiatric diagnosis and treatment to the **Center for Positive Change, LLC; c/o Timothy D. Berry, Ph.D., 2831 Fort Missoula Rd, Ste 106, Missoula, MT 59804**~ 406-830-3808 ~ fax 775-243-9945; tim@cpchange.com

Health Care Provider: _____

Address: _____

_____

(City) (State) (Zip)

Approximate Date of Care: _____

SIGNATURES:

Signed: _____ Date: _____

If other than patient, indicate relationship: _____

(Conservator/Guardian)

Signed: _____ Date: _____

Office use only:
Requested information on _____

(Date)

Received information on _____

(Date)