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, PhD., Autumn Berry MSW
800 Kensington Ave, Ste. 208, Missoula, MT 59801
Phone: 406-830-3808 ~ Fax: 775-243-9945; tim@cpchange.com, autumn@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)