Eagle's Earth Treatment Centre
P.O. Box 4000
Constance Lake, ON P0L 1B0
Tel: (705) 960-2626

Authorization for Release of Information

I, _____, authorize Eagle's Earth Treatment Centre to use or disclose information from my personal files, which may include information about psychiatric diagnosis, medical issues and treatment and substance abuse issues to:

_____

Organization Name

_____

Contact Name (if applicable)

Information to be released (Please describe):

_____
_____
_____

Purpose of Disclosure:

_____
_____
_____

1. I understand that, unless withdrawn, this authorization will expire in 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time.
3. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment, except where disclosure of the information is necessary for the treatment.
4. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____

Signature of Client Date