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# General Consent Form
# Authorization of Disclosure

**Client Name: _____ DOB: _____**

I, _____ (Patient or Patient Guardian)

authorize Roots to Wings, LLC to release to and/or obtain from:

_____
(name and title of person(s) or organization(s) to which disclosure is to be made)

the following confidential written and verbal information, including, but not limited to facsimile and electronic communication, for the following purpose:

_____

I understand that this consent to release and obtain information may be revoked by me at any time except to the extent that the program, which is to make the disclosure, has already taken action in reliance on. However, I realize that this consent remains in effect until so revoked. The consent, unless revoked previously, expires on termination of treatment or on

_____.
(specific date, event or condition of expiration)

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent or Guardian: _____

Relationship to Patient: _____ Date:_____