



P: 587-844-6287  
F: 855-719-0483  
support@talkwithfrida.com

## Consent to Release Personal Health Information:

I, \_\_\_\_\_, DOB: \_\_\_\_\_ authorize:

Name of Clinic or Physician: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

to disclose my personal health information to PurposeMed Frida

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### The records will include:

Records Requested:

(Standard response may be: "Assessment, diagnosis and treatment plans")

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\_\_\_\_\_  
Patient Signature

(wet or digital signature are both valid)

\_\_\_\_\_  
Date