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

Consent to Disclose Personal Health Information:

I, _____, DOB: _____

authorize Frida to disclose my personal health information to:

Name of Practitioner: _____

Clinic Name: _____

Clinic Address: _____

Phone: _____

Fax: _____

Records Requested:

(Standard response may be: "Assessment, diagnosis and treatment plans throughout the duration of time as a patient at Frida" so that we can release everything within their entire date range here and not a specified date)

_____

_____

_____

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_____

_____

_____

Patient Signature

(wet or digital signature are both valid)

_____

Date