Grand Island Mental Health
& Medical Clinic, LLC

Release of Schedule Information

Patient's name: (First) ________________________________ (Last)________________________________

Patient's date of birth: (mm/dd/yyyy) __________ / __________ / __________

Would you like Grand Island Mental Health to release schedule information to someone other than the patient/guardian? This could include past appointment dates, future appointments dates, creating an appointment, and/or canceling an appointment. Yes / No

Name of authorized person: (First) ______________________________ (Last)______________________________

Phone number of authorized person: (__________) __________ - __________

This consent is active for the duration of treatment or until terminated by the client.

Was this a verbal release completed by a staff member or provider of Grand Island Mental Health and Medical Clinic, LLC? Yes / No

Patient/Guardian Signature: ____

Name of staff member/provider who took the verbal authorization: ___________________________________

Date: __________ / __________ / __________