

Cruz Clinic
Integrative Psychology of Ann Arbor

Release of Information

Patient Name _____ Date of Birth _____

The following individuals may contact Cruz Clinic for the following reasons:

NAME	PHONE	RELATIONSHIP TO CLIENT
_____	_____	_____
_____	_____	_____

Please check all that apply:

- ___ Call to schedule/cancel/change an appointment
- ___ Inquire about or inform the clinic about patient's insurance/or patient liability
- ___ Other _____

This authorization will not expire unless requested by the patient.

Patient Signature

Date

Witness

Date