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
_____	_____
_____	_____

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 patient.

_____ _____
Patient Signature Date

_____ _____
Witness/Cruz Clinic Employee Date