HARMONY UNITED PSYCHIATRIC CARE

Consent for Release of Information for Emergency Purposes

I consent to Harmony United Psychiatric Care to release information on an emergency basis only to the following people. (Please print the full legal name, relationship to you, the Child or the Client and their contact info.)

1. _____
   Print Full Name | Relationship | Cell/Home Phone

2. _____
   Print Full Name | Relationship | Cell/Home Phone

_____
Print Name of Client/Patient or Parent/Legal Representative

_____ _____
Signature of Client/Patient or Parent/Legal Representative Date