the blossom method

Release of Information

I,___________________________authorize ___________________________, a therapist with The Blossom Method to discuss my treatment with ___________________, in order to work together to provide comprehensive treatment. The Blossom Method has my permission to speak with all psychiatrists and all medical staff involved in my care from ________________until______________.

____

Patient Signature   Date

233 E. Erie Street #306
Chicago, Illinois 60611
312.854.0061
www.theblossommethod.net