



The Light Point Healing Center
Peggy A McFarland, MS
P.O. Box 26, Hines, OR 97738
541-573-8000
www.thelightpoint.org

Authorization to Disclose Information

I hereby authorize Peggy A McFarland, MS, d.b.a. *The Light Point Healing Center* to disclose the following information to:

Name: _____

Address: _____

City/State/Zip: _____

Phone/Email: _____

In regard to _____ date of birth _____

Information to Be Disclosed (Check all that apply)

- Progress Notes from _____ to _____
- Initial Assessment
- Treatment Plan
- Discharge Summary
- Entire Chart (subpoena only)
- Letter dictated
- Billing information/appointments
- Other (Please specify) _____

I understand that I may revoke this authorization at any time. Authorization must be done in writing. Unless revoked, this authorization will be valid for 12 months from the dated signed.

I understand that signing this authorization is completely voluntary.

Please sign Full Name

Date

Peggy A McFarland, MS

Date