GRAND AVENUE CLUB

Confidential Release of Information

Date: _____

Individual who is subject of record:

Name: _____ Date of Birth: _____

Address: _____

Phone number: _____

Individual requests and authorizes information from:

Psychiatrist or Licensed Provider: _____

Clinic or hospital: _____

Phone #:_____ Fax #:_____

Information to be released to:

Grand Avenue Club Membership Team
210 E. Michigan Ave.
Milwaukee, WI 53202
Phone (414) 727-3366 Fax: 414-276-1606
Email: membership@grandavenueclub.org

The purpose for releasing this information is to coordinate services at Grand Avenue Club.
I understand that I may revoke this authorization, in writing, at any time except where information has already been released. Unless revoked, this authorization will remain in effect through six months from the date signed.

As evidenced by my signature, I authorize disclosure of information to Grand Avenue Club.

_____ _____
Signature of the individual who is subject of record Date