

VOLUNTEER RELEASE OF  
INFORMATION AUTHORIZATION



**Mental Health**  
ASSOCIATION IN GREENSBORO  
*Advancing Mental Wellness*

I hereby freely give my permission to COMPEER to **obtain/release/exchange**  
treatment information **from/to/with:**

(cross out non-applicable words)

(cross out non-applicable words)

\_\_\_\_\_  
Name of Agency or Professional

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

(\_\_\_\_\_) \_\_\_\_\_

Ext \_\_\_\_\_

Phone Number

Concerning the following client:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Birthdate)

Regarding his/her appropriateness to become a COMPEER volunteer. I understand that  
this release is applicable for a period of one year beyond the date below.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of client or guardian  
(cross out non-applicable words)

\_\_\_\_\_  
(Please print name)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date