# Online Wellness Association

## PROFESSIONAL REFERENCE

Applicant

Effective Date

## AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO ONLINE WELLNESS ASSOCIATION (OWA)

Name & Address of Information Source – Please Print or Type:

Relationship to Applicant:

I hereby authorize the above named source to release or disclose to Online Wellness Association information for the period(s) of time identified above:

1) Professional references, relationships, and information verifying my personal integrity as a Practitioner.
2) Information regarding my professional qualifications and experience.

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at any time. If I do not void this authorization, it will automatically end when a final decision is made on my application for membership.

Signature of Applicant:

Date:

Street Address:

Telephone Number (area code):

City, State, Zip Code:

e-mail address: