THERAPY Connections

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AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that the information released may be subject to release by the person(s)/agency receiving it and no longer protected by the federal privacy regulations. I also understand that I may **revoke** this authorization/consent by notifying **Therapy Connections, LLC**, in writing, of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by **Therapy Connections, LLC,** in reliance on it before I revoked it. I understand that I may **refuse** to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

A copy of this authorization will be as valid as the original.

Client name: ____ DOB: ______________

Address: ____ Zip: ____________

I authorize **Therapy Connections, LLC**, to: ☐ receive information from, and/or ☐ release information to:

Agency/Individual: ____

Address: ____ Zip: __________

Phone: ______________________________ Fax: ______________________

Information to be released/exchanged (check all that apply): ☐ verbally and/or ☐ in writing

☐ **All records and ongoing communication** ☐ Name ☐ Address ☐ Phone number ☐ Date of Birth

-- OR --

☐ Diagnostic Report ☐ Treatment Plan ☐ Progress Report ☐ Family/Social History

☐ Testing Results ☐ Medical History ☐ Social Services Case Records ☐ School Records

☐ Psychological Evaluation ☐ Psychiatric Evaluation ☐ Discharge Summary

☐ Other ________________________

All records pertaining to mental health, alcohol and/or drug abuse, and/or AIDS/AIDS-related illnesses will be released unless otherwise indicated in writing here: ____

This release is required for the purpose of: ☐ Coordination of services ☐ Court/Legal action
☐ Determination of eligibility for services ☐ Social Service involvement ☐ Continued/Follow-up care

☐ Other ________________________

I understand this authorization will expire in one year or: ______________________ (not more than 1 year).

This form must be fully completed before signing.

______________________ **(Client)** ____________ **(Date)**

______________________ **(Parent/Guardian/Representative, if applicable)** ____________ **(Date)**

______________________ **(Witness)** ____________ **(Date)**

Date of records requested: ____________