2498 Dayton-Xenia Rd.
Beavercreek, Ohio 45434
Phone: 937-427-1919
Fax: 937-427-1949

Therapy Connections, LLC

RELEASE OF INFORMATION

Client's Name: _____ DOB: _____Parent's Name: _____

PLEASE RELEASE INFORMATION TO….

1. Name/ Facility: _____Phone _____Fax_____

   Address: _____
   Street City State Zip
2. Name/ Facility: _____Phone _____Fax_____

   Address:_____
   Street City State Zip
3. Name/ Facility: _____Phone _____Fax_____

   Address: _____
   Street City State Zip

I allow release of the following information (please initial all that apply):
_____Medical Records (Progress Reports)
_____Diagnostic Tests (Evaluations)
_____All Medical Records from other providers which have been sent to you (Everything on record/ in file)
_____Speaking rights & consultation with facility or person

This authorization shall be in force and effect for one year unless an earlier date is specified, at which time this authorization to use or disclose this protected health information expires. The authorization will automatically expire after one year. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Joyce Peet at Therapy Connections. I understand that a revocation is not effective to the extent that Therapy Connections has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Therapy Connections will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law or state law.
- Refuse to sign this authorization.

_____ _____
Signature of Parent/ Guardian Date