Aiding Therapy Services, PLLC

"Because we all need a little help sometimes."

Authorization to Release Information

I, _____, authorize Aiding Therapy Services, PLLC and its employees to release information to:
(client name)

_____
(Name of person, hospital/agency/company)

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

The released information and notes here authorized is required for the following purposes:

- ❑ Educational
- ❑ Legal
- ❑ Medical
- ❑ Psychiatric
- ❑ Psychological
- ❑ Other:_____

The specific type information that shall be revealed are:

- ❑ All Information
- ❑ Presence in Treatment
- ❑ Verbal and/or Written Progress
- ❑ Admission/Discharge Summary
- ❑ Treatment Plan
- ❑ Other: _____

The information is to be two-way: Yes No

This authorization shall be valid until: _____

I certify that this authorization has been presented willfully and that to my knowledge, the information entered above is correct. I understand that this information cannot be released or received from/to any other person or organization without my written consent. A photocopy of this authorization shall be considered valid. The information given and/or required shall not be used for any other purpose than for what has been authorized. I understand that I have the right to revoke this authorization. I understand that once the information has been released, it can no longer be protected. I release Aiding Therapy Services, PLLC and the aforementioned person/hospital/agency/company from all liabilities and responsibilities that may result from releasing and disclosing this information.

_____ _____
Client Signature Date

I revoke this authorization and in so doing, understanding that no further information may be disclosed between the above mentioned parties.

_____ _____
Client Signature Date

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(office): 720.372.3680 **www.aidingtherapy.com**