Therapy Solutions
TAKE YOUR LIFE BACK.

# Release of Information

Patient Name: _____ D.O.B.: _____ Phone #: _____
(Please Print)

Address: _____
Street or P.O. Box City State Zip Code

Therapy Solutions is hereby authorized to obtain, exchange, and/or disclose information regarding my health care and treatment.

**Release Information From:**

| |
|---|
| **Provider/Facility Name:** |
| **Address:** |
| **City/State/Zip:** |
| **Phone:** |

**Release Information To:**

| |
|---|
| **Provider/Facility Name:** |
| **Address:** |
| **City/State/Zip:** |
| **Phone:** |

*Date(s) of treatment to be released*: _____

*Release method*: ☐ Mail ☐ Pick-Up ☐ Patient Portal ☐ Fax: _____
☐ Phone ☐ Email: _____

*Information to be released*: ☐ Initial Examination ☐ Re-Evaluation ☐ Other: _____
☐ Daily Notes ☐ Discharge

*Information to be obtained*: ☐ MRI ☐ CT Scan ☐ Other: _____
☐ X-Ray ☐ Operative Report

*Reason for disclosure of information*: ☐ Diagnosis and Treatment ☐ Insurance Processing ☐ Legal Process
☐ Benefit Management ☐ Billing/Payment ☐ Disability Claim
☐ Other: _____

I understand that this authorization is voluntary. Therapy Solutions will not condition treatment on your signing this authorization, unless treatment is research related or Therapy Solutions is providing you with healthcare for the sole purpose of a third party report, such as an employer or school. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that I may revoke this authorization at any time by notifying Therapy Solutions in writing, but if I do, it will not have any effect on any actions that Therapy Solutions took before it received the revocation.

This authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____

_____ _____ _____
**Signature** (Parent or legal guardian if a minor or an adult unable to sign) **Relationship to Patient** **Date**