THRIVE
THERAPY STUDIO

Child, Teen, and Adult Psychotherapy
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Authorization for Release of Information

Client Name: _____ DOB: _____

Address_____ Phone Number_____

My signature below hereby authorizes Thrive Therapy Studio to exchange information contained in my medical record, specifically authorizing the release of information relating to my mental health treatment, in either verbal or written form, and/or by fax, with:

Name of Person/Facility _____

Address _____

Phone/Fax _____

Purpose of disclosure: _____
(Legal, School, Consultation, Continuing Care, Referral, Continuity of Care, Other)

I give permission for information to be released in written or verbal form, or via fax, to the above specified individual or to personnel at the above specified agency. I understand that this Authorization will expire one year from the date of signature below, unless specified otherwise. I understand that I have the right to request an accounting of any instances that information is released to other parties. I understand that this Authorization may be revoked at any time.

Expiration Date_____

_____ and/or _____ Date_____
Signature of client Signature of parent/legal guardian