**Release of Information**

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows your therapist at TheraVault, LLC to release and/or exchange your protected health information. You can revoke this authorization at any time by submitting a request in writing to the agency. Revoking this authorization will not affect any action taken prior to receipt of your written request.

**Section I. Client Information:**

Full Name:

Date of Birth:

Address:

Phone:

**Section II. Therapist and/or Agency**

I authorize TheraVault, LLC to release and/or exchange my protected health information to (only one per Release of Information Form):

PCP:

Phone:

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist:

Phone:

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:

Relationship to client:

Phone:

Address:

For the purpose of:

\_\_ Coordination of care. \_\_\_ Intake assessment/discharge summary

\_\_\_ Psychological testing Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How information can be communicated to (check all that apply):

\_\_ Oral

\_\_ Written

\_\_ Electronic

\_\_Other:

Section III. Client signature: By signing below I authorize the release of my protected health information as described above.

Client Signature:

Date:

Clinician Signature:

Date: