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
(client name)
release information to:

_____

(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

11001 W 120th Ave Suite 400; Broomfield, C0 80021

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