ATTUNE THERAPY GROUP, P.C.

AUTHORIZATION FOR THE RELEASE OF TREATMENT INFORMATION

Patient Name: _____ Today's Date:_____

Date of Birth: _____

I authorize Attune Therapy Group, P.C., to release protected health information to:

_____

I am requesting Attune Therapy Group, P.C. to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose).

_____

☐ Reimbursement by my insurance company

Unless otherwise revoked, this Authorization will expire on _____.
(Insert Date or Event)

I have been informed of my right to inspect the records or materials to be released. Please disclose the following information for dates of service from _____ to _____:
(Date) (Date)

(CHECK OFF ALL THAT APPLY)

☐ Summary of Treatment
☐ Psychiatric Evaluation
☐ Treatment Notes
☐ Diagnosis/procedure codes
☐ Other (Please Specify): _____

I understand I have the right to revoke this authorization, in writing at any time by sending such written notification to Attune Therapy Group, P.C. office address. However, my revocation will not be effective to the extent that Attune Therapy Group, P.C. has taken action in reliance on the authorization.

I understand that Attune Therapy Group, P.C. generally may not condition psychotherapy services upon my signing an authorization unless the psychotherapy services are provided to me for the purpose of creating health information for a third party.

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE STATUTE. STATE REGULATIONS LIMIT YOUR RIGHT TO MAKE ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT PRIOR CONSENT OR AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Date

[PROVIDE A COPY OF THIS FORM TO THE CLIENT]