Adaptable Therapy Services, LLC: Medical Release of Information Form

Client/Driver's Information:

Name: ______________________________

Date of Birth: ________________________

Address: ____

I ______________________________ (client's name or POA) hereby authorize Adaptable Therapy Services, LLC. to discuss the details of my case and release the results of the evaluation and treatment provided, to my referring physician, state licensing administration, and others identified below.

Referring Physician

- Physician Name ______________________________
- Physician's Contact Information ______________________________

In addition, I ____________authorize Adaptable Therapy Services, LLC. to discuss the details of my case with the following family contact.

List at least one family member's name/contact number with whom this information may be shared:

- Family Name & Relationship: ____
- Contact's phone number: ____

In addition, results of my evaluation and treatment may be shared with:

- Name, relationship, & contact: ____
- Name, relationship, & contact: ____

____ ________________________
Client Signature Date

____ ________________________
Provider Signature Date