Release of Information

I,_____authorize Branches Therapy Network, PC

to: ☐Disclose ☐Obtain ☐Disclose and Obtain

the following information (including date range):_____

_____

_____

with the following entity:_____

for the following reason(s):_____

and permit information to be disclosed using any of the following (marked) methods:

☐Phone ☐E-mail ☐Text Message ☐Copies of listed documentation (may require a fee)

This authorization is valid for one calendar year (365 days) unless this Release of Information is terminated in writing by the client. Any lawful information disclosed prior to the date Branches Therapy Network, PC acknowledges (in writing) the client's termination of this document request cannot result in any liability for Branches Therapy Network.

Branches Therapy Network, PC cannot be held responsible for the re-release of information by entities the client authorizes to receive information.

It is understood that any records may contain sensitive information including alcohol/substance abuse, mental health, developmental disabilities, HIV/AIDS or other diagnoses, etc. Any restrictions must be noted here:_____

_____

Branches Therapy Network, PC will release documents within 30 days after full payment of any required fees (if applicable) has been processed.

Refusal to thoroughly complete and sign this form will result in no information being disclosed.

_____

Client Signature Date/Time

_____

Witness Signature Date/Time

(If the designated client is under age 12, legal parent/guardian must sign)