Envision Therapy, PLLC
Authorization for Release of Information

Client Name: _____ Date of Birth: _____

I hereby authorize Envision Therapy, PLLC to disclose my protected health information as described below.

Individual or Organization to whom Protected Health Information may be disclosed:
Name: _____
Address: _____
City, State, Zip: _____
Telephone/Fax: _____

Purpose of Disclosure: _____.

This Authorization permits the disclosure of the following information (check all that apply):

___ All Records
___ Assessment
___ Diagnosis
___ Psychosocial Evaluation
___ Psychological Evaluation
___ Psychiatric Evaluation
___ Treatment Plan or Summary
___ Current Treatment Update
___ Medication Management Information
___ Presence/Participation in Treatment
___ Demographic Information
___ Nursing/Medical Information
___ Toxicological Reports/Drug Screens
___ Educational Information
___ Discharge/Transfer Summary
___ Continuing Care Plan
___ Progress in Treatment
___ Other: _____
___ Other: _____

Disclosure shall include records from the following dates of service: _____ to _____. This Authorization expires on: _____, unless sooner revoked. If a calendar date is not stated, information may only be released on the date the Authorization is received.

I understand:

- I have a right to revoke this Authorization at any time by sending a written request to Envision Therapy. However, I understand that such revocation will have no effect on actions already take by Envision Therapy in reliance on this form.

- Unless otherwise revoked in writing, this Authorization will automatically expire one (1) year from the date of my signature below, or upon occurrence of the following event: ___ _____

- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, to the extent applicable, the recipient may be prohibited from re-disclosing substance use disorder information under the Federal Substance Abuse Confidentiality Requirements.

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- I release Envision Therapy, as well as its agents and employees, from any liability in connection with the use or disclosure of the Protected Health Information covered by this Authorization.

- I have the right to inspect and copy the information to be disclosed, and I may refuse to sign this Authorization.

- Envision Therapy may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

- I authorize the disclosure described herein. I have read and understand this form. I am the Patient listed on this form or am authorized to act on behalf of the Patient as the Patient's Personal Representative.

* * *

Signature of Client or Client's Personal Representative:_____

Client / Personal Representative Name: _____

Date:_____

Address:_____ City:_____ State: ____ Zip:_____

DOB:_____ Phone:_____

Relationship/Authority of Personal Representative: _____