

tel: 479-301-5754 fax: 1-866-643-9041

## **Consent to Release Information**

This Consent to Release Information is **HIPAA** compliant. It is intended for the person/persons to whom it was addressed. If you receive this in error, please shred all copies and discard or return.

Patient Name		
Date of Birth		
1	hereby give permiss	ion to Therapy Tree, LLC
to obtain and release any and all i	nformation about my chi is, or billing, pertaining to	ld concerning his/her care. Therapy o his/her treatment for the purpose of
To/From:		
	address	phone#
Physician or Healthcare Provider		
	address	phone#
Physician or Healthcare Provider		
	address	phone#
Physician or Healthcare Provider		
	address	phone#
Physician or Healthcare Provider		
I give permission for my therapist email at home. Please check one a		medical information on my voicemail or
YES NO	email:	telephone:
Days of Counting of Signature	Data	
Parent/Guardian's Signature	Date	