Therapy Roots, LLC
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Authorization for Release of Information

Patient Legal Name: _____DOB: _____

Address (street, city, state, zip): _____

I authorize **Therapy Roots, LLC** to release information to and/or from (circle preference) the following providers:
MD: _____

OT/PT/SLP: _____

ENT: _____

Orthodontist: _____

School: _____

Other: _____

Purpose of Release (select all that apply):

- ☐ Assessment/Treatment
- ☐ Coordination of Care/Follow Up
- ☐ Acknowledgement of Patient's access of service/referral
- ☐ Legal
- ☐ Education
- ☐ Discharge Planning
- ☐ Other
- ☐ All the above

I understand that I amy revoke this authorization at any time, except to the extent that previous action has been taken in reliance of the Authorization for Release of Information. My signature means that I have read this form and/or have had it read to me and explained in a language that I can understand. Authorizing the disclosure of this information is voluntary, and I can refuse to sign this authorization without consequence to my treatment, eligibility for benefits, or payment status. Once authorized information is released, Therapy Roots, LLC cannot prevent the re-disclosure of that information. I hereby release them from any and all liability arising directly or indirectly from disclosure authorized by this consent, and any re-disclosure of that information. I understand that this authorization remains in effect for one year from the date of signature or _____(specify date/event/conditions)

_____

Signature of patient (caregiver if under 18+ relationship) +Print Name Date: