Therapy at Play, Inc.

Authorization to Release Protected Health Information

I hereby authorize Therapy at Play, Inc. to release my protected health information to:

____

Agency/Individual Name

____

Address

____

Phone Number

____

Fax Number

For the purpose of:

____

____

____

I authorize release of the following:

____

____

I understand that I may revoke this authorization at any time by submitting a written request to the Center. Such a revocation does not apply to releases prior to the date of the request.

_____________________________________ ____________________

Client or Legal Guardian Date