Authorization to Release/Obtain Confidential Information

I __________________________ hereby authorize and request that Simply Thrive Therapeutic Associates, PLLC may release to or contact the following individuals, groups, or insurance, for matters of my well-being and/or payment, any confidential information regarding the diagnosis and treatment of myself or my minor child________________.

Names to contact or release to: Phone #/ Address

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This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event ____.

After giving due consideration to the extent of this release, I authorize Simply Thrive Therapeutic Associates PLLC to furnish information, including photo-static copies of my psychological records concerning my treatment, t the above individual, organization, or to its agents. I further agree to indemnify and hold harmless Simply Thrive Therapeutic Associates PLLC from all liability that may arise from the release of the information herein requested. Any information released in response to this authorization should not be re-released to any other person(s) unless I so specifically authorize.

I understand that the records released may contain alcohol and drug treatment information, medical information, AIDS/HIV information, or psychiatric and psychological information. I understand that my records may be protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42, CFR Prt. 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Signature: ____

Date:____________

Therapist's Signature:

_______________________________Date:____________