Rowan Therapy
Box 91
Thornton, PA 19373

Authorization to Release and Request Confidential Information

Re: (Client Name) ______________________________ Date of Birth: ____________________

Client Address: ____

Phone Number / Fax / Email: ____

By signing below, I authorize Rowan Therapy to release information to ______ (check)

or to obtain information from ______ (check)

Provider's Name & Contact: ____

____

Only the following checked information is covered under this release:

______ Verification of presence in treatment
______ Background information
______ Medical information
______ Progress Notes
______ Legal information
______ Psychological evaluation
______ Educational records
______ Treatment records
______ Diagnostic summary
______ Admission / discharge information

Other: ____

This release shall remain in effect for one year after its signing or until rescinded – either verbally or in writing.

This form has been explained to me and I understand its contents.

Date: ____

Client/Parent/Guardian signature: ____

Provider's signature: ____