Authorization for Release of Information

I give Therapy Corps, PLLC permission to use or share my health information with:

____

The information that will be used or shared includes (check all that apply):

- ☐ My medical records
- ☐ My treatment records (progress notes, daily records)
- ☐ My speech & language test reports and therapy notes
- ☐ Other: ______________________________

This information is being used or shared because:

collaboration with Therapy Corps, PLLC

This authorization will expire:

- On 365 days from this notice
- After the following eventhappens: Patient/POA request

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can reverse this authorization at any time. I need to write to Therapy Corps, PLLC, 1713 Richcreek Road; Austin, TX 78757 to reverse this release.
- Any information that was used or shared before I reverse this authorization cannot be returned.
- The person or organization that receives exchanged health information because of this authorization may have the right to share it with others without my permission.

______________________________	______________________
Print Patient's Name	Date
______________________________	______________________
Patient or Parent/Guardian Signature	Relationship to Patient