

 AUTHORIZATION FOR RELEASE

 OF

MEDICAL INFORMATION

I authorize **Therapy In Your Home – OT, PT,ST t**o communicate regarding the information checked below with the following people or groups (add contact information if possible):

*You may also designate here if there is someone you DO NOT want us*

*to communicate with or information you DO NOT want communicated:*

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\_\_\_ Medical records

\_\_\_ Communications related to the client

\_\_\_ Other data needed for assessment, treatment, planning and reporting.

\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_

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Signature

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Printed Name/ Authorization if needed TIYH: Release of Medical July 2015