Authorization for Release of Information

Client Name: _____
Date of Birth: _____

I authorize Advanced Therapy of America to release medical information to and/or collaborate with the following individuals:

☐Insurance companies
☐Schools including teachers, assistants, supervisors, and all pertinent staff members
☐Physicians
☐Other healthcare professionals
☐Other: _____

I authorize Advanced Therapy of America to send brief/or detailed messages to the following:

☐Home phone
☐Cell phone
☐Text Messaging
☐E-mail

I authorize Advanced Therapy of America to use the following media sources for therapeutic and training purposes:
☐Photos
☐Videos

I DO NOT wish the following individuals to receive any healthcare information:
_____
_____
_____

_____ _____
Date Signature of Individual or Representative

_____
Authority or Relationship to Individual, if Representative