treehouse counseling

Neuro-affirming therapy for children and families

Authorization for Release of Information

Client Name: _____Date of Birth: _____

Phone Number: _____

Treehouse Counseling: Check All That Apply	Outside Person or Organization:
☐ Release Information ☐ Receive Information ☐ Verbally or Electronically Exchange Information	Name of Person or Organization:
Treehouse Counseling, LLC	Address:
Address: 1255 S. Market St. Suite 203	City, State, Zip:
Elizabethtown, Pa 17022	Phone:
PH: 717-740-3739 FAX: 717-389-4695	Fax:
Information to Be Released (Check all that apply):	
☐Billing Information	☐ Behavioral Report
☐Education/Academic Records	☐Psychological or Neurological Evaluation
☐Progress Notes	☐Psychiatric Records
☐Teacher's Report	
☐Other (Please Specify):	
☐Entire Medical Record for Specified Date Range:	
Purpose of Release:	
☐ Legal	☐ Transfer of Care
☐ Continuing Care	☐ Other (Please Specify):
☐ School	
Authorization for General Release of Information:	
I authorize Treehouse Counseling, LLC to release, receive, or exchange information from the above-mentioned individual's record as stated. You may amend or revoke this form in writing to Treehouse Counseling, LLC. ***Note: Please complete form in its entirety. Failure to do so may delay or deny processing of your request. Release will be valid until termination of treatment or authorization from client revoked.***	

_____ _____

Client Signature Date

_____

Parent or Guardian Signature (If client is under 18)