Arrow Therapy

LETTING GO. MOVING FORWARD.

Consent to Release

I authorize _____ to release to, obtain from, and discuss with _____ the following (check one):

□ any and all confidential information and records concerning my therapeutic treatment.

□ billing records only

□ (other)_____

I waive my right to confidentiality of the information and records released, obtained and discussed under this Consent. I release Arrow Therapy and its staff from all liability arising from release, disclosure and discussion of my confidential information and records.

I acknowledge I have the right to revoke this Consent in writing at any time to the extent action in reliance on this Consent has not been taken. I acknowledge that even if I revoke this Consent, the use and disclosure of my protected health information could possibly still be compelled as required by law. I have been advised of the potential of the redisclosure of my protected health information by the authorized recipients.

I acknowledge that the treatment provided to me by Arrow Therapy was not conditioned on my signing this authorization.

I acknowledge I signed the original and received a copy of this Consent to Release.

DATED: _____, 201__.

_____
Client Signature

_____
Client Name Printed

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