Restored Hope Therapy Services, PLLC
8594 Park Dr. Mt Pleasant NC 28124
restoredhopetherapyservices@gmail.com
980-290-7311

Authorization to Exchange, Obtain or Release Information

Client Name: _____ Date of Birth: _____
Home Address: _____
_____

I _____ (client or family member) hereby grant Restored Hope Therapy Services, PLLC permission to communicate with the following person or agency:

Name:

Contact Information:

Information to Be Released:

☐ Medical History

☐ Therapy Evaluation

☐ Treatment Notes

☐ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of: (check all that apply)

☐ Coordinating care with other professionals

☐ Providing continuity of services

☐ Updating therapeutic progress

☐ Other _____

☐ **I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.**

☐ **I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.**

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client