HIGH POINT FAMILY
THERAPY SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize: High Point Family Therapy Services, PLLC
Clinician: _____
Mailing Address:
4332 Grassy Moss Drive
Greensboro, NC 27409
Phone: 336-505-5484
FAX: 336-505-5483

To release to: Name: _____
Organization: _____
Address: _____
_____
Phone: _____
FAX: _____

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Organization: _____
Address: _____
_____
Phone: _____
FAX: _____

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Clinician: _____
Mailing Address:
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Greensboro, NC 27409
Phone: 336-505-5484
FAX: 336-505-5483

___ Diagnosis, Services Provided, Dates
___ Treatment Summary
___ Assessment Report
___ Psychological Testing Information
___ Medical History, Physical Exam
___ Other _____

This information will be used for my evaluation, treatment, follow-up care, and/or to determine benefits payable and claim insurance for treatment services.

I hereby release both of the above parties from any liability that may result from furnishing the information released. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that, in any event, this consent shall expire 90 days after completion of services provided by High Point Family Therapy Services, PLLC.

Date: _____ Client Name: _____ DOB _____

Witness: _____ Client Signature_____
Parent/Legal Guardian _____

Revised 12-16-17