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RELEASE OF INFORMATION

I authorize Shannon Thornton, M.A., LPC, DBA Chrysalis Behavioral Therapy and Counseling, to release records or information, OR to obtain records or information regarding the below named person(s). These records may include any medical records, academic records, psychological or neuropsychological evaluations, treatment notes, diagnosis, recommendations, or any other information that is related to my care.

I authorize my records and information to be released to or obtained from the following individuals or entities:

Full Name: _____

Phone: _____

Address: _____ Fax: _____

Full Name: _____

Phone: _____

Address: _____ Fax: _____

Full Name: _____

Phone: _____

Address: _____ Fax: _____

This authorization shall remain in effect for one year from the date of signing or until otherwise stated. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient or Guardian _____
Date_____

If signed by a guardian, please state legal basis for guardian status:
