Authorization for Release/Exchange of Information

Becoming Through Sound Music Therapy Services
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This form provides your therapist at Becoming Through Sound with written permission to communicate with other individuals regarding your treatment.

Client: _____

Name of Third Party (physician/person/facility): _____

Address of Third Party: _____

Telephone number of Third Party: _____

_____ I authorize for Becoming Through Sound to release the following information about my therapy services to the above noted Third Party.

Information to be released or exchanged (check all that apply)

____ Intake and history ____ Diagnosis and treatment plan ___ Verbal consultation

____ Treatment progress ____ Discharge Summary ___ Billing and Payment

____ Other (specify): _____ ___ All of the above

_____ I authorize for the Third Party to release the following information to Becoming Through Sound.

Information to be released or exchanged (check all that apply)

____ Intake and history ____ Diagnosis and treatment plan ___ Verbal consultation

____ Treatment progress ____ Discharge Summary ___ Billing and Payment

____ Other (specify): _____ ___ All of the above

This release shall be valid until the termination of treatment or until withdrawn in writing by the client during the course of treatment.

_____

Client printed name (acceptable if over 14)

_____ _____

Client signature (acceptable if over 14) (Date)

_____

Parent/Guardian printed name (required if client is under 14)

_____ _____

Parent/Guardian signature (required if client is under 14) (Date)

_____ _____

Maevon Gumble, MMT, MT-BC (Date)