Creekside
Collaborative Therapy LLC

Authorization for Release of Medical Records

Name of Client *

First Name Last Name

Name of Person Completing Form (if different than client):

First Name Last Name

Relationship to client if person completing form is not client

Email *

example@example.com

Last 4 SSN of Client *

Type of Information to be Released *

(List as specifically as possible, for example: name, dates of service, any documents).

Purpose for Information Release *

Release Information to the Following

Name *

First Name Last Name

Phone Number *

Email Address *

Delivery Method *

Records are being request for the following purpose: *

- Continued Medical Care
- Legal Purposes
- Insurance Purposes
- Personal Interest
-

Where records should be sent (if being mailed):

Street Address

Street Address Line 2

Release Date Expiration (recommendation is one year past today's date but cannot be longer than two years past today's date) *

Month Day Year

Consent *

☐ I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Consent *

☐ I understand that there is no charge for my records to be sent electronically by secure email. However, I will be charged $15 for the first 10 pages and $.50 for each additional page if I request that my records be mailed to me or to someone else.

Consent *

☐ I understand that if I choose to have my records sent electronically via encrypted email, there is a risk that electronic communications may be compromised, unsecured, and/or accessed by a third party despite Creekside sending such records in a secure and encrypted format. If I chose this format, I acknowlege those associated risks.