Fly Family Therapy, Inc.

Therapy, Neurofeedback, Assessment
www.flytherapy.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Parent Name (if under 18): ______________________ Social Security #: ______________________

I request and authorize ____ to release information regarding medical, psychological, and mental health treatment information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

I authorize release of information via fax, email, or phone: (please initial here) __________

Fax number: ______________________ Email address: ______________________________

Phone number: ______________________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Patient (or Parent, if under 18) Signature: ______________________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER IT IS SIGNED.

718 J. Clyde Morris Blvd.
Newport News Va. 23601

Phone: 757- 873-8566
Fax: 757-595-1885