COMMUNITY THERAPY SERVICES
AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: ______________________________________

☐ **Authorization to Release Information to Community Therapy Services (CTS)**
I consent to the release of information and/or disclosure to CTS of the following records:

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From: _________________________________ Phone/Address: ______________________________________

From: _________________________________ Phone/Address: ______________________________________

From: _________________________________ Phone/Address: ______________________________________

This authorization to release information to Community Therapy Services shall be valid for the duration of services unless notified otherwise in writing. A photocopy or fax of this authorization is to be accepted with the same authority as the original.

☐ **Authorization for Community Therapy Services (CTS) to Release Information**
I authorize CTS to release the following records:

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To: _________________________________ Phone/Address: ______________________________________

To: _________________________________ Phone/Address: ______________________________________

To: _________________________________ Phone/Address: ______________________________________

This authorization for Community Therapy Services to release information shall be valid for one year unless notified otherwise in writing. A photocopy or fax of this authorization is to be accepted with the same authority as the original.

____ ______________________

Signature of Parent/Guardian Date