AUTHORIZATION TO SHARE MEDICAL INFORMATION

Client Name: _____

Date of Birth: _____

I authorize Teletherapy Group LLC to share my: (Please check all that apply)

- O Scheduling Information
- O Medical Information
- O Billing Information
- O All Information

Please list any exclusions for information:

_____

With the following Person(s)

Name	Phone Number	Relationship to Client
Name	Phone Number	Relationship to Client
Name	Phone Number	Relationship to Client
Name	Phone Number	Relationship to Client

OR

O I do NOT authorize Teletherapy Group to release any of my medical information to anyone, with the exception of coordination of benefits (i.e. insurance) or continuation of care (i.e. referrals).

This authorization will remain in effect until revoked in writing by the above listed client.

Client Signature _____ Date _____