PROFESSIONAL THERAPY SERVICES, INC.

1015 OAKHURST DRIVE
CHARLESTON, WV 25314

TELEPHONE: (304) 345-8101 / Fax: (304) 345-7386

"PLAYING TO SUCCEED"

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, hereby authorize ________________________ to release and disclose to ___________________________________, the following information:

____

____

____.

The purpose of this use or disclosure is as follows:

____

____

____.

This authorization expires on ___________ and may be revoked by submitting a written notice of revocation to Professional Therapy Services, Inc.

I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on my signing this authorization.

I understand that protected health information used or disclosed pursuant to this authorization may be re-disclosed by the recipient.

____ ______________________

Patient/Personal Representative Date

____ ______________________

Patient Name Date of Birth

If signed by the Personal Representative of the patient, describe the Personal Representative's authority to act for this patient:

____

____.