Tanglewood Therapy

CONFIDENTIALITY POLICY

Patient Name:_____ Patient DOB: _____

Patient Social Security Number:_____

The relationship between patient and therapist is a confidential one. Information will not be released from this office regarding your therapy without your expressed permission, with the exception of emergency or requirement by law, as outlined in the HIPPA policies. If you wish information released to anyone, it will be necessary for you to complete a release of information form, stipulating the professional to whom the information is to be sent.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Tanglewood Therapy, LLC to provide/request:

Name:_____

Address:_____

Phone: _____

Name:_____

Address:_____

Phone: _____

With the following health information:

___ Initial Evaluation

___ Treatment Plan

___ Treatment Notes

___ Progress and Treatment Updates

For the purpose of: _____

A scanned copy of this authorization shall be considered as effective and valid as the original. Please sign upon upload.

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