Advanced Therapy Solutions

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's Name:_____

Address:_____

(Street Number, Post Office Box) (City) (State) (Zip Code)

I/We (_____) authorize exchange of medical information between
parent/guardian name
Advanced Therapy Solutions and the following healthcare provider, attorney, counselor, school district, etc.:

_____
(Individual, Physician, Hospital, Clinic, Attorney, Counselor, School, etc).

_____
(Street Number, Post Office Box) (City) (State) (Zip Code)

to release the following specific confidential information:

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for the therapist(s) at:

Advanced Therapy Solutions LLC, 936 Silas Deane Highway, Wethersfield, CT 06109
Phone (860) 721-9999 Fax (860) 721-9903

I understand that: (1) I may revoke this authorization in writing by contacting Advanced Therapy Solutions LLC that obtained the authorization, (2) this authorization will not affect treatment, payment, enrollment, or eligibility for benefits, and (3) information disclosed as a result of this authorization could be subject to re-disclosure as authorized by law.

Please note: All Initial Evaluations and Treatment Plans will be faxed to your child's pediatrician unless you choose otherwise. Please check:

- ☐ **I <u>do not</u> want my child's information sent to the pediatrician.**
- ☐ **Instead of my child's pediatrician, please forward the reports to my child's naturopathic physician, neurologist, developmental pediatrician, etc. (please specify):**

_____

Expiration Date: This authorization will expire one year from the signature date.

_____ _____
(Signature of Parent/Guardian) Date

936 Silas Deane Highway 3rd flr, Wethersfield, CT 06109, 860-721-9990
www.advancedtherapysolutionsct.com