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Email: ot.life.balance@gmail.com

Teaching Healthy Routines In Various Environments

PERMISSION TO SHARE AND RELEASE INFORMATION
Duo Release Form

THRIVE Group Participant's Name:_____

DATE OF BIRTH: _____

I hereby authorize THRIVE group leaders (Rachel Renick and Sally Stauffer), to share information regarding the evaluation and treatment of (named participant above) for the purposes of treatment planning and coordination. I authorize the release of such information as the treating therapist deems relevant and pertinent to the professional listed below.

I also authorize THRIVE group leaders to obtain information about my treatment from the provider listed below. I authorize the provider to release complete information from the medical, school, social service and/or psychological record of (named participant above).

NAME OF PROVIDER/ VR COUNSELOR:_____

ADDRESS: _____

_____

PHONE NUMBER: _____

NAME OF PROVIDER: _____

ADDRESS: _____

_____

PHONE NUMBER: _____
***Please provide additional provider information on back, if necessary.**

_____ _____

Signature of THRIVE Group Participant **Date**