Brittany Graniero-Rothman, LMHC-QS, CCTP,CYT
3632 Land O Lakes Blvd, Suite 105-7
brittany@deeplyrootedtherapyandwellness.com
941-214-0046

Release of Information

Authorization for the use and disclosure of Protected Health Information (PHI) is only for the person or agency on this form.

Client Name:	DOB:	Today's Date:

I, _____, authorize Brittany Graniero-Rothman, LMHC, whose office is located at 3632 Land O' Lakes Blvd, Suite 105-7 to release/exchange by phone, fax, email or mail my PHI with the following provider:

_____

Reason/Purpose for Disclosure:

- ▢ Collaboration
- ▢ Insurance
- ▢ Continued Care/Treatment
- ▢ Payment
- ▢ Legal
- ▢ Other:

The PHI to be disclosed includes the following:

- ▢ Assessment Information
- ▢ Diagnosis
- ▢ Treatment Planning Notes
- ▢ Progress & Treatment Notes
- ▢ Medication
- ▢ Recommendations
- ▢ Results of Psychological Testing
- ▢ Psychiatric Evaluation
- ▢ Reasons for Termination
- ▢ Other:

Date Records Released:

Release Expires:

- ▢ End of 60 days
- ▢ Termination of Treatment
- ▢ As of:

Notes:

By signing below, I acknowledge that the above information about me may be released, discussed, or disclosed. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to my therapist/clinician.

_____ _____ _____

Client Signature Date Print Name