



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, request and authorize The Therapy Network to forward copies of any and all information pertaining to my treatment including reports, daily notes, etc. to the individual or group listed below.

In consideration of the agreement I affix my signature for approval.

Signature / Date

To: _____

Office Use Only:

Account Number: _____

Chesapeake Ghent Kempsville Independence Oceana Witchduck First Colonial