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# Therapy Connections, LLC

## RELEASE OF INFORMATION

I give my consent for Therapy Connections, L.L.C. to release information concerning the services provided to the client named below to the following person(s), hospital, school, clinic, or agency.

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Consent to release the following information to:

1. Name: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

2. Name: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

3. Name: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Signature of Client or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

*Discover Abilities ... Achieve Results... Experience Success.*