Columbus Therapy Associates
1335 Dublin Road, Ste 200B, Columbus OH 43215 www.ColumbusTA.com p: 614-595-9037 TherapyTeam@ColumbusTA.com f: 614-448-4702

Authorization to Release Protected Health Information

Client's Name: _____ Date of Birth: _____

Columbus Therapy Associates, LLC is authorized to release or request my/my child's protected health information to or from:

Agency/Individual's Name	
Agency/Individual's Address	
Agency/Individual's Phone Number	
Agency/Individual's Fax Number	
Purpose of the Release	
The following information may be released/ requested	

This authorization may be revoked at any time by submitting a written request to Columbus Therapy Associates. Such a revocation does not apply to releases prior to the date of the request.

Responsible Party Signature (Adult Client or Parent/Legal Guardian): _____

Responsible Party Printed Name (Adult Client or Parent/Legal Guardian): _____

Date: _____