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

Client's Name: _____ Date of Birth: _____

Authorization to Release Protected Health Information

I hereby authorize Columbus Therapy Associates to release my protected health information to:

_____
Agency/Individual Name

_____
Address

_____
Phone Number

_____
Fax Number

For the purpose of:

_____

_____

_____

I authorize release of the following:

_____

_____

I understand that I may revoke this authorization at any time by submitting a written request to the Center. Such a revocation does not apply to releases prior to the date of the request.

_____ _____
Client or Legal Guardian Date