360 Talk Therapy
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Release Of Information (ROI)

Authorization for the use and disclosure of protected health information.

I authorize 360 Talk Therapy to release and/or receive the protected health information described below.

Patient Name _____

Date of Birth _____

Release To / From (Name) _____

Organization _____

Phone _____

Fax _____

Address _____

Information To Be Released

- ■ Psychiatric evaluation
- ■ Medication list / prescriptions
- ■ Progress notes
- ■ Discharge summary
- ■ Lab results
- ■ Other (specify below)

Other / specify

Purpose Of Disclosure

This authorization expires 12 months from the date signed unless otherwise noted. I understand I may revoke this authorization at any time in writing, except to the extent action has already been taken.

Patient/Guardian Signature: _____ Date: _____