The Atrium
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Phone: 215-550-1818
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Release of Information Form

By signing this release, I give my therapist, _____, consent to speak with the care provider listed below regarding my case.

Person/Provider Name:

Relationship to Patient:

Information To Be Released: ___Diagnosis ___Treatment Process and Progress
___All Medical Records
___Other (Please specify):

Person/Provider Phone Number:

Person/Provider E-Mail:

Patient's Name: Date:

Patient's Signature:

Name of Parent or Guardian: Date:

Signature of Parent or Guardian: