



Helping Hands Therapy Services, PLLC  
Virginia Beach, VA  
Phone: 757-550-0725 Fax: 888-306-7078

[www.helpinghandstherapyservices.com](http://www.helpinghandstherapyservices.com)

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***Authorization to Release Information***

Patient's Name:

Date of Birth:

I, \_\_\_\_\_ (patient/legal guardian) hereby authorize **Helping Hands Therapy Services, PLLC** permission to communicate with the following person or agency:

Name:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Regarding the following information and as part of their current treatment plan:

- |   |  |
|---|--|
| <input type="checkbox"/> Previous Medical History   | <input type="checkbox"/> Current Medical Concern   |
| <input type="checkbox"/> Previous Therapy Treatment | <input type="checkbox"/> Current Therapy Treatment |
| <input type="checkbox"/> Other                      |  |

I understand that my authorization will remain effective from the date of my signature for 12 months and that the information will be handled confidentially in compliance with all applicable federal laws. I understand that I may revoke the authorization at any time. I have read and understand the nature of this release.

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

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