Drayton's View
Therapy and Wellness Services, PLLC
Where Healing Meets Perspective
910-929-2103 | connect@draytonsviewtherapy.com | draytonsviewtherapy.com
130 Pine State Street Suite C, Lillington, NC 27546

# Release of Information

**Client Name:** _____
**Date of Birth:** ____ / ____ / _____
**Phone Number:** _____

---

**1. Information To Be Released**

I hereby authorize **Drayton's View Therapy and Wellness Services, PLLC** to:

☐ Release Information to
☐ Obtain Information from
☐ Exchange Information with

**Name/Organization:** _____
**Address:** _____
**Phone:** _____ **Fax:** _____

---

**2. Type of Information to Be Released (check all that apply)**

☐ Intake/Assessment
☐ Treatment Plans
☐ Progress Notes
☐ Discharge Summary
☐ Medication/Medical Records
☐ School Records
☐ Other: _____

---

**3. Purpose of Release (check all that apply)**

☐ Coordination of Care
☐ Continuity of Treatment
☐ Legal Purposes
☐ Insurance
☐ Other: _____

Updated: 11/1/2025

Drayton's View
Therapy and Wellness Services, PLLC
Where Healing Meets Perspective
910-929-2103 | connect@draytonsviewtherapy.com | draytonsviewtherapy.com
130 Pine State Street Suite C, Lillington, NC 27546

---

**4. Expiration of Consent**

This authorization will expire **one year** from the date signed unless otherwise specified:
Expiration Date: ____ / ____ / _____

---

**5. Client Rights**

- I understand I may revoke this authorization at any time in writing.
- I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
- I understand that treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization.

---

**6. Consent & Signatures**

I have read and understand this Release of Information. I authorize the release/exchange of information as indicated above.

**Client/Guardian Signature:** _____ Date: ____ / ____ / _____
**Witness/Staff Signature:** _____ Date: ____ / ____ / _____