Thrive Therapy Group, P.C.
Mental Health Professionals

42500 Hayes Rd. Ste. 500
Clinton Township, MI 48038

Phone: (586) 828-1221
Fax: (586) 421-4705

Date: _____

To: _____
_____
_____

I authorize the above stated person or party to release records to Thrive Therapy Group, P.C.

Patient Name: _____

Patient Signature: _____

Attached is the above patient's signed authorization for release of records. Please forward the records indicated below to:

Thrive Therapy Group
42500 Hayes, Rd. Ste. 500
Clinton Township, MI 48038
(586) 828-1221
OR:
Fax to (586) 421-4705

___ Mental Health Records to include the following:
- ___ Psychological/Psychiatric Evaluation
- ___ Medication Review(s)
- ___ Psychotherapy Notes
- ___ Diagnosis
- ___ Treatment Plan

___ Medical records from _____ to _____
(date) *(date)*

___ Other_____

_____