AUTHORIZATION FOR DISCLOSURE

Client Name: _____ DOB: _____
I hereby authorize the release/exchange of information between Premier Pediatric Therapy (PPT) and to the following persons and/or agencies listed below for the purposes of assessment, treatment planning and/or coordination of services:

NAME: _____
ADDRESS: _____
PHONE: ( ) _____ FAX: ( ) _____

NAME: _____
ADDRESS: _____
PHONE: ( ) _____ FAX: ( ) _____

NAME: _____
ADDRESS: _____
PHONE: ( ) _____ FAX: ( ) _____

NAME: _____
ADDRESS: _____
PHONE: ( ) _____ FAX: ( ) _____

Please check mark on the list below which documentation regarding your treatment may be released and/or exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.
☐ Evaluation Report
☐ Treatment Notes
☐ Discharge Summary
☐ Other (Specify) _____
☐ I authorize periodic exchange of relevant clinical information.

I understand that the federal privacy law protecting health information may not apply to the recipient of the information and therefore, may not prohibit the recipient from redisclosing it. I understand what information will be released, the purpose for the release of the information, and that there are statutes and regulations protecting the confidentiality of the information. PPT's NOTICE OF PRIVACY PRACTICES describes the circumstances where disclosure is permitted or required by state or federal laws.

I understand the terms of the Authorization for Disclosure and voluntarily give my authorization. I understand that I may refuse to sign this authorization form. PPT will not condition my evaluation or treatment on receiving my signature on this authorization. I further understand that I may revoke this authorization by written request at any time. Such revocation does not affect the validity of my authorization for information disclosed/released prior to revocation. If not revoked earlier, this authorization expires one year from the date it is signed.

Signed: _____ Date: _____