Pediatric Therapy Links, LLC

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Authorization for Release and Disclosure of Protected Health Information

Patient Name: _______________________________________ Patient DOB: _____________

This form is used to release or disclose Protected Health Information as required by state and federal laws. Your authorization allows the release of your and your child's Protected Health Information to the individual or organization that you choose.

I authorize Pediatric Therapy Links, LLC to release to/ or obtain Protected Health Information to/ from the following:

Name: ________________________________ Relationship: ___________________ Phone: ___________________

Name: ________________________________ Relationship: ___________________ Phone: ___________________

Name: ________________________________ Relationship: ___________________ Phone: ___________________

Name: ________________________________ Relationship: ___________________ Phone: ___________________

Complete Records: Any and all personal and protected health information.

Check all that apply:

Evaluation Reports	Discharge Summary	Attendance Log
Billing Records	Plan of Treatment	Progress Summary
Treatment Notes	Other: __________________	

The purpose of this release of information:

Provide continuity of patient care	Coordinate Treatment	Personal Use
Educational	Other: ______________________________	

This consent form may also allow personal and protected health information to be shared via a telephone call with the individual or organization being authorized.

Your authorization is voluntary and may be revoked at any time by submitting a request except when the submission of medical records have already taken place in response to this authorization.

This authorization will expire on _____________________. If no date is noted, this authorization will expire in twelve (12) months from the date it was signed.

I authorize the use or disclosure of personal and protected health information described above to the individual(s) or organization(s) identified above. I understand that once the information is disclosed per this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

____ ____________________________

Signature of Patient/ Parent/ Legal Guardian Date