Health Information Release Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. However, such revocation will not be retroactive.
- The practice may condition receipt of treatment upon execution of this consent.

*I authorize **321 THERAPY** to have access to any and all of my child's health records. **321 THERAPY** is permitted to share health information with those listed below, including test results and information obtained during office visits.*

Please initial beside persons authorized to receive medical information:
Please include name and phone.

___ Child's Physicians _____

___ Family/Caregiver _____

___ Early Steps _____

___ School _____

___ Other _____

You may notify me with test results, appointment reminders, and other information regarding my health information as follows:

___ Message on answering machine Phone # _____
___ Message on work voicemail Phone # _____
___ Message on cell phone Phone # _____
___ Text message on cell phone Phone # _____
___**Therapist may contact me from their personal devices in order to discuss my child's care.**

_____ _____ _____
Patient/ Guardian Print Name Patient/Guardian Signature Date

_____ _____ _____
Witness Print Name Witness Signature Date