Creative Therapy
Occupational • Physical • Speech-Language
Mental Health Therapy

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Authorization to Exchange, Obtain or Release Information

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

_____

I _____ (client or family member) hereby grant Creative Therapy/Seasons Pelvic Floor & More permission to communicate with the following person or agency:

Agency or Person: _____

Contact Information: _____

Information to Be Released:

☐ Medical History
☐ Evaluation/Plan of Care ☐ SLP ☐ OT ☐ PT ☐ Other: _____
☐ Treatment Notes ☐ SLP ☐ OT ☐ PT ☐ Other: _____
☐ Mental Health Records/Plan of Care
☐ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of: (check all that apply)

☐ Coordinating care with other professionals
☐ Providing continuity of services
☐ Updating therapeutic progress

☐ Other _____

☑ I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.
☑ I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse
☑ I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this Authorization is valid for one year.
☑ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the above referenced medical care provider.
☑ A photostatic copy of this Authorization, or carbon copy shall be construed as effective and valid as the original and that treatment, payment or health care operations cannot be denied upon the granting or denial of this authorization.
☑ Once protected health information is released, there is a potential for redisclosure by a recipient and such information may no longer be protected health information.

_____ _____
Printed Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client