AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 child's Protected Health Information to the individual or organization that you choose.

Child's Name:_____ **D.O. B:** _____

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

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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

Check all that apply:

☐ Evaluation Re-evaluation Reports
☐ Plan of Treatment
☐ Treatment Notes
☐ Progress Notes
☐ Discharge Summary
☐ Billing Records
☐ Invoices
☐ Attendance Log
☐ Other: _____

The purpose of this release of information:

☐ Provide continuity of patient care
☐ Educational
☐ Coordinate Treatment with another provider
☐ Personal Use
☐ Other: _____

This consent form may also allow personal and protected health information to be shared via 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 Parent/Legal Guardian Date

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