AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

I am completing this form to allow the use and sharing or protected health information about:

Patient Name: ______________________________ **Date of Birth:** ______________

I authorize disclosure of my child's protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below:

Please release information to:

Impressions Pediatric Therapy
7500 Marlboro Pike, Suite A,
Forestville, MD. 20747
Phone:301.238.4788
Fax:301.298.5442

I want information released from:

Impressions Pediatric Therapy
7500 Marlboro Pike, Suite A,
Forestville, MD. 20747
Phone:301.238.4788
Fax: 301.298.5442

From: ______________________________

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To: ______________________________

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I authorize Impressions Pediatric Therapy to disclose the following information:

- ☐ All the below
- ☐ Evaluation Report
- ☐ Treatment session notes
- ☐ Billing records
- ☐ Complete copy of the medical record
- ☐ Other: ______________________________

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I understand and agree that this authorization will be valid and in effect for 12 months after completing this form. I understand that after that date, no more of this information can be used or released by Impressions Pediatric Therapy, unless I sign a new authorization form. I can revoke consent at any time, provided that the revocation is in writing.

Signature: ______________________________ **Date:** ______________

Relationship to the patient: ______________________________