THERAPY INNOVATIONS, LLC
WWW.THERAPY-INNOVATIONS.COM
414|241|8008

Acknowledgement of receipt of Privacy Practices Notice
HIPAA Consent to Use & Disclose Health Information

Section A: Client Information
Name of Patient: _____

Name of Parent / Guardian: _____

Relationship to Patient: _____

Address: _____

Telephone: _____ Email:_____

Section B: Acknowledgement of Privacy Notice
□ I acknowledge that I have received a Notice of Privacy Practices from Therapy Innovations LLC.

Section C: Consent and Release of Information:
CONSENT FOR PHOTOGRAPHS AND VIDEOS This consent enables the therapist to take videos or pictures of your child participating in the therapy activities. These videos and pictures may be shared with you, teachers, and other team members.

□ I consent the therapist taking a video or photograph for therapeutic and/or educational purposes.
□ I do not consent. Please do not take video or photographs of my child.

CONSENT FOR EXCHANGE OF INFORMATION WITH OTHER PROFESSIONALS When students have other professionals supporting them, it is helpful to share information about programming and recommendations. Examples include other therapists, teachers, daycare/preschool staff, and medical doctors.
□ I do consent to Therapy Innovations, LLC exchanging relevant information in confidence with related professionals.
□ I do not consent. Please do not exchange information.

It has been our experience that some clients prefer electronic correspondence regarding their care. Therapy Innovations LLC does NOT have HIPAA-compliant (encrypted) email service.

□ I give my permission to correspond via email regarding my dependent's care.
□ I give my permission to discuss via phone and/or text messages regarding care.
□ I give my permission to leave clinical information and/or appointment reminders on voicemail.

Section D: Signature

Signature: _____ Date: _____

Print Name/Relationship: _____