Phone: (406) 471-9910
Fax: (406) 309-2076

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

CLIENT NAME: _____
ADDRESS: _____
DATE OF BIRTH: _____

I authorize Healthy Beginnings Pediatric Therapy to release information <u>TO and FROM</u>:

Name or Provider or Facility:_____

Address, City, State, Zip:_____

Phone#, Fax #:_____

Periodic Use/Disclosure: I authorize the periodic use or disclosure of the above named individual's health information to the person/provider/organization/facility/program(s) identified as often as necessary. Information to be released: Entire (complete record).

- I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in the federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time by contacting Healthy Beginnings Pediatric Therapy (406-471-9910)
- I understand that this revoke does not apply to information that has already been released in response to this authorization.
- Failure to sign this authorization will have no adverse impact on delivery of care.

Unless otherwise revoked, this authorization will expire:

- ☐ When the individual named above is no longer receiving services from Healthy Beginnings Pediatric Therapy
- ☐ One year from this date
- ☐ Other _____

Disclosure Method:

- ☐ Pickup
- ☐ Mail
- ☐ Fax
- ☐ Verbal

Signature of Parent or Legal Representative:_____Date:_____

Relationship to Client: _____

Signature of Witness _____