Impressions pediatric therapy

Exceptional Care For Your Children

# 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**
5801 Allentown Rd., Suite. 410
Camp Springs, MD. 20746
Phone: 301.238.4788
Fax: 301.298.5442

**I want information released from:**

**Impressions Pediatric Therapy**
5801 Allentown Rd., Suite. 410
Camp Springs, MD. 20746
Phone: 301.238.4788
Fax: 301.298.5442

**From:** _____

_____

_____

_____

_____

**To:** _____

_____

_____

_____

_____

**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: _____

_____

_____

*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:** _____