



AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

I am completing this form to allow the use and sharing of 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:

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: _____