HAND IN HAND THERAPY

Guiding little hands. Growing big skills.

Release of Information

Person completing form:_____ Relationship to client:_____
Client's name:_____

I authorize Hand in Hand Therapy, PLLC to:
___Send
___Receive

The following information:
___Medical history and evaluations
___Mental health evaluations
___Developmental and/or social history
___Educational records
___Progress notes and treatment or closing summary
___Other

To/From person or company:_____
Phone:_____
Fax number:_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 & 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1 Part 2), pls applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

_____ _____
Legal Guardian Printed Name Relationship to Client

_____ _____
Legal Guardian Signature Date