**AUTHORIZATION FOR EXCHANGE OF INFORMATION**

This form must be completed for every agency you would like us to communicate with. All agencies you work with, including Kids Connect Us, are required by law to keep you and your child’s health information confidential. This document gives us permission to communicate with the individual(s) that are affiliated with the agency listed below regarding your child’s health care needs and medical records. Please submit one page per agency you would like us to communicate with.

**Patient Information:**

Name (First, Middle, Last):

Last 4 Digits of Social Security #:

Address (Street address, City, State, Zip):

**Release Information to the Following (pediatrician, school team, speech, etc.):**

Name of Individual(s):

Name of Facility/Agency:

Address (Street address, City, State, Zip):

Phone:

Email:

**Purpose of Release:**

Continuity of Care, Billing/Payments ☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dates of service for Release:**

☐One year from this date ☐Other date range:

**Information for Release**

☐OT Evaluation/Assessment

☐Occupational Therapy Treatment

☐Medical concerns

☐Psychiatric concerns

☐Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Rights:**

I, the undersigned authorize Kids Connect Us to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness.

**This authorization and consent will expire one year from the date of the authorization written below,** unless revoked through written notice or another date range is indicated above. Any revocation will not apply to any information that was released previously. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

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**Signature of Patient or Authorized Representative Date Signed**