3269 US Hwy 231 Suite #127
Ozark, AL 36360
(334) 625-0323

Release of Information

Patient's Name: _____ DOB: _____ **Phone:**_____

Address: _____ City: _____ State_____ Zip: _____

I,_____, authorize Oz Therapy to:

(Parent or Guardian)

_____ (send) _____ (receive) the following:

_____Academic testing results	____ Testing results
____ Behavior programs	____ Service plans
____ Progress reports	____ Summary reports
____ Intelligence testing results	____ Vocational testing results
____ Medical reports	____ Entire record, except progress notes
____ Personality profiles	____ *Therapy Notes
_____ Assessment & Evaluation reports	_____ Other, specify_____

(to) Name: _____ Fax: _____

(Where do you want the information sent)

Address: _____ City: _____ State: _____ Zip: _____

The above information will be used for the following purposes:

____ Planning appropriate treatment or program	___Determining eligibility for benefits or program
____ Continuing appropriate treatment or program	___ Case review
_____ Updating files	
____ Other (specify) _____	

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand 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.

Your relationship to the Patient:

_____ Self ___Parent/Legal Guardian ___ Personal ___ Other (describe) _____

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.

Signature: _____ Date: _____

Patient

Signature: _____ Date: _____

Parent/Guardian/ Personal Representative

Signature: _____ Date: _____

Witness – if unable to sign

Please fax response to: (833) 974-3021

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *THERAPY NOTES.