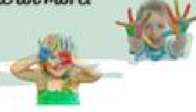
THERAPY.....and a whole lot more!



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:
Building Great Kids Therapy
1738 Eagan Rd.
Madison, WI. 53704
Phone: 608.286.1171
Fax:

I want information released from:
Building Great Kids Therapy
1738 Eagan Rd.
Madison, WI. 53704
Phone: 608.286.1171
Fax:

From: ____________________ **To:** ____________________

I authorize Building Great Kids 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 Building Great Kids 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: ____________________