FOCUS Pediatric Therapy

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AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name_____

Date of Birth _____

Person/Organization given permission to receive information

I authorize FOCUS permission to release information to the person/organization listed above concerning:

- ☐ OT Evaluations and Plan of Cares
- ☐ ST Evaluations and Plan of Cares
- ☐ PT Evaluations and Plan of Cares
- ☐ Discharge Summaries
- ☐ All information pertaining to my child's care

I would also like to give FOCUS permission to receive information pertaining to my child's care from the listed person/ organization.

Sign _____

I authorize FOCUS to use or disclose my Personal Health Information (PHI) as described above. I understand that my participation is voluntary and if the organization authorized to receive my PHI is not a health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have the legal right to review our Notice of Privacy Practice. It is available upon request.

Signature of Parent:_____Date_____

Printed Name of Parent:_____

Signature of Witness_____