A Step Ahead
PEDIATRIC THERAPY

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:

A Step Ahead Pediatric Therapy
2865 Chancellor Dr. Ste. 105
Crestview Hills, Ky. 41017
Phone: 859-426-5666
Fax: 859-426-5665

From: _____

I want information released from:

A Step Ahead Pediatric Therapy
2865 Chancellor Dr. Ste. 105
Crestview Hills, Ky. 41017
Phone: 859-426-5666
Fax: 859-426-5665

To: _____

I authorize A Step Ahead Pediatric 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 until December 31, 2014. I understand that after that date, no more of this information can be used or released by A Step Ahead Pediatric 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 : _____