



## Patient Disclosure Authorization Form

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:

Specific description of information to be used or disclosed:

A Step Ahead Pediatric Therapy

2865 Chancellor Dr. Suite 105

Crestview Hills, KY 41017

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reason \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please circle one:    PT (physical therapy)                      OT (occupational therapy)                      ST(speech therapy)

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Authorization expires one year after date of signature)

Relationship to patient (if signed by a personal representative of patient) \_\_\_\_\_