

## Child'sPlay Therapy Release of Health Information

Client's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dates of Service: from \_\_\_\_\_ to \_\_\_\_\_

**I hereby authorize disclosure of protected health information as follows:**

Organization Sending Information:

Person/Organization Receiving Information:

Child'sPlay Therapy Center

CHILD'S PEDIATRICIAN \_\_\_ YES \_\_\_ NO

3057 Lorna Road Suite 220

Dr.'s Name: \_\_\_\_\_

Birmingham, AL 35216

Practice name/address: \_\_\_\_\_

\_\_\_\_\_

**Type of information to be used or disclosed:**

|                |                 |
|----------------|-----------------|
| OT evaluations | Case History    |
| ST evaluations | Prescriptions   |
| PT evaluations | Billing Records |
| Progress Notes | Other _____     |

**I understand that:**

1. This information about the client is protected under federal law.
2. I may refuse to sign the authorization.
3. I have the right to revoke this authorization in writing.
4. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.
5. Treatment or payment will not be based on my signing this authorization
6. I will receive a copy of this authorization if I request it.

\_\_\_\_\_  
**Signature of Client or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship of Personal Representative to Client**

\_\_\_\_\_  
**Signature of Witness**