Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name: ____

Social Security Number: ______________________________ **Date of Birth:** ____________________

I hereby acknowledge that Advance Rehabilitation for Kids, Inc. may use and/or obtain my health information for the purposes of treatment, payment or other healthcare operations. I also hereby authorize Advance Rehabilitation for Kids, Inc. to use and/or disclose any of my health information related to my current diagnosis, illness and/or injury to individuals and/or groups of individuals listed below (such as family, members of my household, close personal friends or anyone else) by my request so that all my rehabilitation needs can be met. The health information that I authorize to be used and/or disclosed is that information acquired during my care with Advance Rehabilitation for Kids, Inc. and any health information that pertains to my care including past medical history and previous dates of service and those services received up to my discharge from Advance Rehabilitation for Kids, Inc.

Names of Individuals or Groups of Individuals I authorize Advance Rehabilitation for Kids, Inc. to disclose my health information to:

____

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In order to provide continued outpatient services the following is requested:

☐ Occupational therapy

☐ Physical therapy

☐ Speech therapy

☐ Evaluations (Dates) ______________________ to ______________________

☐ Plans of care (Dates) ______________________ to ______________________

☐ IEP (Dates) ____

☐ Psychological Evaluation (Dates) ______________________________________

☐ Other ____

By providing this authorization, I understand as follows:

I understand that this authorization is voluntary. I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected.

1. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
2. I understand that I may revoke this authorization at any time by notifying Advance Rehabilitation for Kids, Inc. in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
3. I understand that I can receive a copy of this authorization form after I sign, at my request.
4. I understand that the Notice of Privacy Practices is posted in the clinic for my review. I also understand that a copy of the Notice is available to me, at my request.
5. I understand that this authorization will expire on _____/_____/_____ (DD/MM/YR) or upon discharge of the patient.

____

Patient Printed Name

____ ____________________

Signature of Parent/ Legal Guardian **Date**

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Relationship to Patient