



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize THERAPEDIATRICS, Inc. to:

- Release to...
- Obtain from...
- Verbally exchange with...

Name _____

Address _____

Phone _____

The following information regarding my child:

Child's Name _____ DOB ____ / ____ / ____

- | | | |
|--|---|---|
| <input type="checkbox"/> Occupational therapy evaluation | <input type="checkbox"/> Speech/ language evaluation | <input type="checkbox"/> Individualized Family Service Plan/ IFSP |
| <input type="checkbox"/> Educational evaluation | <input type="checkbox"/> Neurological evaluation | <input type="checkbox"/> Progress Update |
| <input type="checkbox"/> Psychological evaluation | <input type="checkbox"/> Audiological/ Hearing evaluation | <input type="checkbox"/> Service Update |
| <input type="checkbox"/> Psychiatric evaluation | <input type="checkbox"/> Vision evaluation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Health/ medical examination | <input type="checkbox"/> Individualized Education Plan/ IEP | <input type="checkbox"/> Other _____ |

For the following dates of service (date if applicable): _____

For the purpose of: _____

This authorization is valid from _____ to _____

I understand that my medical/ health information is protected under RI General Laws 5-37.3 and 40.1-5, Federal Privacy Regulations 45 CFR 160-164 and cannot be disclosed without my written consent, except as otherwise specifically provided by law. I also understand that if my records involve alcohol or drug abuse, or HIV (AIDS) testing, they are further processed under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse, and Rhode Island Public Law Chapter 88-405, Section 23.

This consent will have duration of no longer than one (1) year from the date of this form. I understand I may withdraw my consent in writing at any time. I understand that withdrawal will not apply to information already released in response to this authorization. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign the authorization. I understand that I may inspect or obtain information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it a potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules.

- | | | |
|-------------------|------------------------------|-----------------------------|
| Release via Fax | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Release via Phone | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

I have read and understand the above statements and do herein voluntarily consent to disclosure of the above information and/or mental health records, to those persons/agencies named above.

Signature

Relationship

Date