The Therapy SP/OT
A Pediatric Speech & Occupational Therapy Clinic

1216 Selby Avenue
Saint Paul, MN 55105
Phone: 651-698-1729
Fax: 1-855-611-8594

Authorization to Disclose & Release Health Information

Client Name:	Date of Birth:
Parent(s):	Phone:
Address:	
City, State, Zip	

THE PURPOSE OF THIS AUTHORIZATION IS FOR:

☐ **Communicate Verbally RE: Client Services**	☐ **Communicate in Writing & Email**
☐ **Coordination of Care**	☐ **Request Records From Other Providers**
☐ **Psychological Assessment Reports**	☐ **Education Records (including IEP and IFSP)**
☐ **Medication Records**	☐ **Other:**

WITH THE FOLLOWING INDIVIDUALS AND / OR ORGANIZATIONS:

Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**

Note: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524
I understand that if the person or entity receiving this information is not a health plan, health care or other provider covered by federal or state privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying The Therapy SP/OT, LLC in writing and that if I choose to do so, my request to revoke will not affect any actions taken by The Therapy SP/OT, LLC before receiving my revocation. I understand that unless otherwise revoked, this authorization will expire one year from the date it is signed. I understand I may see and request a copy of information received and that this organization reserves the right to charge me for said copies. A photocopy or fax of this authorization will be treated in the same manner as an original. In consenting, I understand information obtained is confidential and may be used only for the purposes discussed and may not be released to other requestors without my consent. I understand this consent is not required for consideration for services and my health care will not be affected if I do not sign this form. I have been informed that The Therapy SP/OT, LLC will not receive financial or other compensation for disclosing the health information described above.

_____ _____
Parent/Legal Guardian/Client Date

Relationship to Client:

☐ Mother	☐ Father	☐ Foster Parent	☐ Social Worker	☐ Grandparent

Privacy Notice: You have a right to be told the intended use and purpose of information requested, whether or not you can legally refuse to provide the information, what might happen if you provide or refused to give the information, and who, besides you, will be able to see the information you furnish.