Connections Pediatric Therapy
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CONNECTIONS
PEDIATRIC THERAPY

HIPAA Agreement

Client's Name_____ Date of Birth_____

As parent/legal guardian, I hereby authorize Connections Pediatric Therapy to obtain and release specified medical records/information from and to the following:

_____ _____

_____ _____

_____ _____

Information to be released:

___ Evaluations
___ Plan of Care(s)
___ Medical Records
___ Progress Notes
___ Health History/Sensory History
___ Other _____

Specific information NOT to be released:

_____

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization. If to do so would be prohibited by state and federal law. I understand that an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization, those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions that have taken place in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt required, to the Privacy Officer at Connections Pediatric Therapy.

Once health information is disclosed to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

_____	_____
Patient/Legal Authorized Representative	Date
_____	_____
Printed Name	Relationship to Patient
_____	_____
Witness	Date

NOTE: This document must be made part of the patient's medical record. A copy of this must be given to patient or legally authorized representative upon request.