Authorization for Release of Protected Health Information.
In accordance with state and regulatory agency requirements, the medical record is the property of KidWorks.

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

I hereby authorize that my medical information be released:
TO/FROM

_____
_____
_____

KIDWORKS THERAPY SERVICES
3607 Manchaca Road
Austin, TX 78704
512-444-7219

Please release the following information:
___Initial Evaluation ___Re-evaluation ___Progress Notes ___Plan of Care
___History and Physical ___Discharge Summary
___Other (Specify) _____

This information is necessary for the following purpose:

___Continued Patient Care ___Insurance ___Personal Use ___Other (specify) _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the administrative office of KidWorks Therapy Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company or referring doctor when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will not expire.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that with certain exceptions I may inspect or request copies of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the office manager at (512) 444-7219.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name Relationship to the Patient

This information has been disclosed to you from records protected by federal law (42 USCA Sec. 290-dd (2). Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 USCA Sec.290-dd(2).