NORTHSHORE
pediatric therapy

AUTHORIZATION TO RELEASE INFORMATION

Client Name: ____ **DOB:** _______________________

Street Address: ___________________________ **City/State:** ____________________**Zip:** _____________

I understand this release is voluntary and applies to all programs and services operated at Northshore Pediatric Therapy. I understand that my personally identifiable information ("PII") and personal health information ("PHI") may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act ("FERPA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and/or other applicable state or federal laws and regulations. I understand that my PII and PHI may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. I understand that I may revoke this authorization at any time by notifying Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy in writing, but if I do, it will not have any effect on any actions taken before receipt of the revocation. This release once signed will remain in effect for two years unless otherwise revoked.

I hereby authorize Rebecca Cummings, M.S., CCC-SLP, PLLC, d.b.a. Northshore Pediatric Therapy to (check all that apply): ☐ Exchange information with ☐ Release information to ☐ Obtain information from

The following Organization/Individual in regard to the above named client:

Name of Organization/Individual:

____

Address: ____

City: ____________________________State: ____________Zip: _______________

Phone: _________________________ Email:________________________________

I hereby authorize this information to be exchanged in the following manner(s):
☐ Verbal only ☐ Written form only ☐ Both verbal and written communication

Description of information to be exchanged / released / obtained (select all that apply):

o Education records
o Evaluation/assessment/eligibility records
o Medical records
o Clinical records (including but not limited to behavior analytic, psychiatric, psychological or mental health, physical, occupational, and speech therapies)
o Other: ____

Purpose: This information is being disclosed for the following purpose:diagnostic, treatment planning and continuity of care.

Signature of Parent or Legal Guardian: ______________________________________ Date: ______________________

Print Name of Person signing form: _____________________________________ Relationship to Client:___________

Records Released by: ____ Date: Released: ____________________

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