APEX PEDIATRIC THERAPY SERVICES

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RELEASE OF CHILD'S INFORMATION CONSENT

Child's Name: _____

Address: _____ City: _____ State: _____Zip: _____

Phone: _____ DOB: _____

I, _____ , authorize Apex Pediatric Therapy Services, LLC to send and receive the following information from my child's insurance company, physician, psychologist or school if needed.

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *THERAPY NOTES.

Academic testing results	Psychological testing results
Behavior programs	Service plans
Progress reports	Summary reports
Intelligence testing results	Vocational testing results
Medical reports	Entire record, except progress notes
Personality profiles	Therapy Notes
Psychological reports	____Other, specify_____

The above information will be used for the following purposes:

Planning appropriate treatment or program
Continuing appropriate treatment or program
Determining eligibility for benefits or program
Case review or Updating files

I also authorize Apex Pediatric Therapy Services LLC to share _____'s progress summary report with his/her psychological evaluation clinician, _____ on a periodic basis as well as receive copy of the psychological testing results report from the clinician.

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.
I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to child: _____Parent _____Legal guardian
If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Parent/Guardian's Signature: _____ Date: ____/_____/_____