TherapyWorks
4 Kids, LLC™

Phone: (803) 548-9113 Fax: (803) 548-9116 1162-A Fort Mill Hwy, Indian Land, 29707

Authorization to Release Protected Health Information

I hereby authorize TherapyWorks 4 Kids, LLC to release the protected health information of:

Patient name: ______________________________

Date of birth: ______________________________

To:

☐ Pediatrician ______________________________

☐ Physicians ______________________________

☐ Family Members ______________________________

☐ School/teachers ______________________________

☐ Early Intervention ______________________________

☐ Other ______________________________

For the purpose of:

☐ Collaboration of care

☐ Other ______________________________

I authorize release of the following in document form or verbally:

☐ Therapy Evaluations/Goals

☐ Therapy notes

☐ Therapy progress

☐ Medical history/concerns

☐ Other ______________________________

I understand that I may revoke this authorization at any time by submitting a written request to TherapyWorks 4 Kids, LLC. Such a revocation does not apply prior to the date of request.

______________________________ ______________

Parent or legal guardian signature Date