Kid O'Therapy, LLC
41 Main Street
Topsham, Maine 04086
P: (207) 844-8287
F: (207) 844-8245

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

This authorization complies with 45 CFR § 164.508(c) (HIPAA)

Patient: _____ **Patient's Date of Birth**: _____

I hereby authorize _____ to furnish, discuss and release all information and records requested below in writing covering findings, treatment rendered, and opinions as to my condition as authorized below
to_____
__.
Dates of Protected Health Information to be released:

- from _____ to _____
- and for the next 12 months or until I revoke this Authorization, whichever comes first. Purpose of this Authorization to Release Health Care Information:
- to develop and coordinate my treatment plan
- to communicate contraindications, precautions, progress and/or recommendations for return to work, athletic/sports activities or other functional activities
- to pursue legal/liability claims
- to comply with the patient's request
- Other:
  _____
  _____
  _
  _____
  __
  _____
  _____
  __
- Records authorized to be released:
- Examination/Evaluation records
- All treatment records
- Diagnostic tests (MRI, X-rays, CT Scan, EMG/NCV testing, and any other diagnostic tests) in my records regardless of who created the records.
- Other:
  _____
  _____
  _

ACKNOWLEDGEMENTS:

- I understand, and voluntarily consent, to disclosure of information to the extent stated above. A copy of this

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- Authorization shall have the same force and effect as the original. Subsequent disclosures may be made under this
- Authorization.
- The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, if so, may
- not be subject to federal or state law protecting its confidentiality.
- I may revoke this authorization at any time by executing a written revocation, subject to the rights of any individual
- who acted in reliance on the authorization prior to receiving notice of revocation. This revocation will be signed and
- dated by me and will state that all or part of this authorization is revoked.
- Upon my request, I am entitled to a copy of this authorization and to inspect or copy information disclosed hereunder,
- pursuant to C.F.R. 164.524.
- I understand that no enrollment or eligibility for benefits, treatment or payment is intended or expected to be
- conditioned upon this Authorization.

_____

Patient's Signature Date

_____

Parent or Guardian's Signature Date