3488 Jeffco Blvd, Ste 102
Arnold, MO 63010
Phone: (636) 464-KIDZ (5439)
Fax: (636) 464-5438
www.therapyplay.com

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. I am completing this form to allow the use and sharing of protected health information about Child's Name_____ Date of Birth _____

2. I authorize Therapeutic Playtime Staff and Employees

3. To ___xx__ obtain or ___*xx*___disclose the following information:
   _xx__ Admission and discharge summaries.
   _xx__ Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
   _xx__ Social, family, education, and vocational histories.
   _xx__ Progress, Case, or similar notes.
   _xx__ Evaluations and reports of consultants.
   _xx__ Billing records.
   __xx_ Academic and educational records.
   _xx__Complete copy of the medical record.
   _xx__ Other: Authorize to Disclose Protected Health Information in Public Area: **Discuss Patient Care in areas where other children and families may be present per my request ie example waiting room: Initial Here:_____**
   Dates of care included: ALL
4. **To this person or organization**: _____
5. The information will be obtained/used/disclosed for the following purposes: discuss treatment strategies, plan of care and medical records.
6. I understand and agree that this Authorization will be valid as of date today and in effect until treatment services are discharged. I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization.
7. I understand that I do not have to sign this authorization or I can revoke my authorization at any time, in writing. My refusal to sign or to revoke this authorization will not affect my ability to obtain treatment from the professional or facility listed in #2 above, nor will it affect my eligibility for benefits.
8. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.
9. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
10. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand it.

Printed name of client: _____

Signature of client or guardian: _____ Date: _____

Therapeutic Playtime staff who has discussed this form with the client or his/her guardian.

Signature: _____ Date: _____

Title: _____