CHILDREN'S THERAPY SPECIALISTS

PATIENT AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

Patient's Name:	DOB:

Authorization to RELEASE or OBTAIN Protected Health Information:

I hereby authorize *Children's Therapy Specialists, Inc.* to release or obtain my Protected Health Information through either written, verbal, or electronic modes of communication with the following persons/organizations/facilities (e.g. educational staff, medical providers, social workers, etc):

Please indicate professional's name and position:

_____

Type of Information: (specific description of information, including dates if applicable):

I understand that:

- This authorization must be filled out completely to be valid. A copy is as valid as the original.
- I may revoke this authorization at anytime by notifying *Children's Therapy Specialists, Inc.* in writing, but if I do, it won't affect any actions *Children's Therapy Specialists* took in reliance on this authorization before I revoked it.
- Once information is released to a third party according this authorization, *Children's Therapy Specialists, Inc.* cannot prevent its redisclosure.
- This authorization does not limit the ability of *Children's Therapy Specialists, Inc.* to use or disclose my health information as otherwise permitted by state or federal law.

Print Parent/Legal Guardian's Name:_____

Relationship to Patient:_____

_____ _____

Parent/Legal Guardian's Signature Date

www.childrenstherapymn.com

Phone: 952-955-3323 Fax: 952-955-3324