Peak Potential Therapy

Evidence-based, Developmental & Holistic Approach to Treating Children with Disabilities

Authorization for Use of Disclosure of Protected Health & Confidential Information

Client: _____ DOB: _____

Information about the other organization to which information will be disclosed:

Organization: _____

Office Phone: _____ Fax: _____ Cell: _____

Name of Individual(s): _____

Address: _____City: _____ State: _____ Zip: _____

I hereby authorize the disclosure or release of the following information: (check all that apply)

- ❑ Social History
- ❑ Test Results & Reports
- ❑ Psychotherapy Records
- ❑ Progress Reports
- ❑ Vocational Evaluation Reports
- ❑ Medical/Dental Records
- ❑ Other: _____
- ❑ Intake Assessments & Notes
- ❑ Immunization Records
- ❑ Treatment Plans
- ❑ Educational Records
- ❑ Court Records
- ❑ Discharge Summaries

To Peak Potential Therapy LLC, 7689 Sagamore Hills Blvd., Northfield, OH 44067.

- ❑ This information may be disclosed to and used by all Peak Potential Therapy staff providing direct services to the client following minimum necessary provisions.
- ❑ Use or disclosure of the information is limited: _____

Protected Health Information is being used or disclosed for the following purposes:

- ❑ At the request of the Client, Parent, or Guardian.
- ❑ Other: _____

All matters relating to this individual which are privileged and confidential by law will be treated as such by the personnel/agencies. The information specific above shall be released only among the mentioned personnel/agencies unless otherwise required by law or court. I understand that I have right to revoke this authorization at any time by sending or delivering written notification to Peak Potential Therapy. I understand that a revocation is not effective to the extent that Peak Potential Therapy has already acted on the authorization. I understand that once this authorization is acted upon, the receiving party may be under no legal obligation to maintain the confidentiality of health information and could in turn disclose it to one or more other parties. By Federal Law, Peak Potential Therapy shall not condition the provision of the health care services on whether I sign this document, except as outlined in Peak Potential Therapy policies.

This authorization shall expire one year from date of authorization.

_____	_____	_____
Name of Client or Parent/Guardian	Signature of Client or Parent/Guardian	Date

NOTE:
A copy of this release may be provided to the client or parent/guardian or other organization.
The original of this release will be in the client's file.