Peak Potential Therapy LLC

Speech Therapy with a Developmental & Holistic Approach to Treating Children with Disabilities

Authorization for Use of Disclosure of Protected Health & Confidential Information

Organization: ____

Name of Individual(s): ____

Address: _____________________________City: ___________ State: ____ Zip: ________

Client: __________________________________ DOB: ________________

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

- ❑ Social History
- ❑ Psychological Test Results
- ❑ Psychotherapy Records
- ❑ Progress Reports
- ❑ Vocational Evaluations
- ❑ Immunization Records
- ❑ Photograph
- ❑ Psychiatric Assessments
- ❑ Intake Assessments
- ❑ Treatment Plans
- ❑ Educational Records
- ❑ Court Records
- ❑ Discharge Summaries
- ❑ Medical/Dental Records
- ❑ Other: ____

To Peak Potential Therapy LLC, 8870 Darrow Road, F106 #289, Twinsburg, OH 44087.

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

  ____

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

A copy of this release may be provided to the client or parent/guardian.
A copy of this release will be in the client's file.