

HORN AND ASSOCIATES IN REHABILITATION, PLLC



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Release of Information / Consent to Treatment

Client or Patient's Name

Date of Birth

Parent/Guardian's Name

Patient / Client SS#

Address

City, State, Zip Code

I hereby authorize Horn and Associates in Rehabilitation, PLLC to:

Release: Information and records to Insurance: **YES** **NO**

Release: Information to physicians: **YES** **NO**

Physician Name: _____

RELEASE all information and records regarding the above name patient to the following agencies, or persons:

OBTAIN information and records as selected below regarding the above named client or patient from the following agencies or persons:

Please check information to be obtained/disclosed:

_____ History and Physical Examination

_____ Initial Evaluation

_____ Therapy Notes

_____ Outpatient Clinic Notes

_____ Discharge Summary

_____ X-Ray Report

*Initials are required to disclose privileged information

_____ Psychological/Psychiatric Records _____*

_____ Social Service Records _____*

_____ Other (Specify) _____

I, or custodial parent/legal guardian, give permission for **Horn and Associates in Rehabilitation, PLLC**, to administer and interpret assessments and/or testing measurements, and/or initiate therapy, and/or seek emergency medical treatment if required.

CONDITIONS

- The patient or legal parent/guardian agrees to authorize the above named individuals/organization to access her/her confidential health information only for the purpose listed above.
- The information authorized to be released will not be covered under the federal privacy laws.
- The patient or legal parent/guardian agrees that any sharing of confidential health information with individuals/organization listed above may be mailed, faxed, electronically sent and/or hand delivered.
- The patient or legal parent/guardian is voluntarily signing this authorization.
- The patient or legal guardian/parent reserves the right to refuse to sign this authorization.
- The patient or legal guardian/parent reserves the right to revoke this authorization at any time. The revocation must be in writing.
- This authorization will be maintained by Horn and Associates in Rehabilitation, PLLC, for a period of twelve (12) months.

Through my execution of this authorization, I represent that I have legal authority to authorize the foregoing and agree to hold Horn and Associates in Rehabilitation, PLLC, harmless and indemnify from and against any and all losses and/or claims they may suffer by reasons of breach of the foregoing representation.

I have read, reviewed and agree with: Horn and Associates in Rehabilitation, PLLC *Notice of Privacy Practices*. A copy of these will be given upon request.

Printed Name

Date

Client or Custodial Parent/Legal Guardian Signature

Witness