HORN AND ASSOCIATES IN REHABILITATION, PLLC

2412 Greatstone Point
Lexington, Kentucky 40504

4127 Todds Road
Lexington, KY 40509

Phone (859) 224-4081 Fax (859) 224-4082

www.horntherapy.com

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** **X** **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.

I agree to the supervised participation of health care learners in my care (e.g., resident students, therapy students, graduate students, other clinical students, etc.). I understand my patient records will be held in strict confidentiality and will not be discussed outside the office. _____ **(Initials)**

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