HORN AND ASSOCIATES IN REHABILITATION, PLLC

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2023 ABI Release of Information / Consent to Treat

Client Name:_____Date of Birth:_____

I hereby authorize Horn and Associates in Rehabilitation, PLLC, to release information including the diagnosis, records, evaluation rendered to me, and any other information to establish and maintain good care.

Initials are required to disclose privileged information: _____Pyschological Records _____Social Service Records

This information may be release to and from (2-way release):
Insurance: **YES**___**X**___ **NO**_____
Physician: **YES**_____ **NO**_____
Physician Name:_____
Physical Address:_____
Physician Phone Number:_____

List additional people you choose to have access to this information (e.g., Case Manager, house staff, family members, caregivers, health care professionals)

Name:_____Relationship: ____Case Manager_____
Name:_____Relationship: _____
Name:_____Relationship: _____
Name:_____Relationship: _____

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 and Disclosure Against Surprise Billing*. A copy of these will be given upon request.

Printed Name:_____

Client or Custodial Parent/Legal Guardian Signature:_____Date:_____