HORN AND ASSOCIATES IN REHABILITATION, PLLC

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2023 Release of Information / Consent to Treatment

Client Name:____Date of Birth:________________

I hereby authorize Horn and Associates in Rehabilitation, PLLC, to **release** any 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., other family members, caregivers, health care professionals, teachers/schools)

Name:_____________________________________Relationship: _________________________
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.

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

Printed Name:______________________________________

Client or Custodial Parent/Legal Guardian Signature:__________________________________Date:______________