# HORN AND ASSOCIATES IN REHABILITATION, PLLC

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## 2024 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: _____Psychological Records _____Social Service Records

This information may be released to and from (2-way release):
Insurance: **YES__X__**
Physician: **YES_____NO_____**
Physician Name:_____
Physician Address:_____
Physician Phone Number:_____
**List any 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 his/her confidential health information only for the purposes 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 andAssociates 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._____**(Initials)**

Printed Name:_____

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