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Creative Hands
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# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient's Name_____ Date of Birth: _____

Address: _____

I hereby authorize Creative Hands Occupational Therapy to release records to CDSA (CDSA patients only) and:

_____

Address: _____ Address: _____

Information to Release:

☐ Complete Office Records ☐ Evaluation/Goals ☐ Progress Notes

Creative Hands Occupational Therapy, Inc. also has my authorization to discuss my child's treatment with the following individuals:

_____
_____
_____
_____

I authorize release of my child's records in accordance with the specifications listed above and authorize Creative Hands Occupational Therapy, Inc. to discuss my child's care with the individuals specified above.

CHOT also uses electronic devices & other means to correspond information regarding your child with child's parent(s), fellow practitioners & CHOT therapist for your child's care. We will use reasonable means to protect the security and confidentiality of any electronic communications. If you do not agree, then you ***may not*** use any form of electronic communication with your CHOT therapist including texting.

I understand I may revoke this authorization at any time by signing a separate revocation form.

Parent's Printed Name: _____

Signature of Parent/Guardian: _____ Date: _____

Legal Authority is: ◯ Parent ◯ Guardian (Legal Document Needed)

Witness: _____ Other: (specify) _____