Developmental Therapy Associates
& Absolute Speech and Language Therapy

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Authorization for the Release and Exchange of Healthcare Information to Driver

Many of our patient's parents allow family members and friends (ie grandparents, significant other, aunt, etc.) to bring the patient to appointments. Under the requirements for HIPAA, information about the appointment cannot be relayed to them without parent's consent. If you wish to have your child's information released to anyone, please list them below and sign.

I authorize Developmental Therapy Associates to release my child's information to:

Name	Relationship to Patient

Redisclosure of confidential information is prohibited without client consent. The information should be limited to include information/feedback regarding the visit for the day they bring the patient. If no one is listed, information will not be released.

I understand that I may, at any time, revoke this authorization by written request. Such revocation does not affect the validity of my authorization for information disclosed/released prior to revocation.

Patient Name (Please Print)

Date

Parent Signature