NeuroPlay Studio™ LLC

Pediatric Occupational Therapy

Phone: (352) 729-1796
Email: connect@neuroplaystudio.com
Service Area: Central Florida

NEUROPLAY STUDIO
Pediatric OT

AUTHORIZATION TO RELEASE INFORMATION

Patient Information

Patient Name: _____ **Date of Birth:** _____

Release Information To/From

I authorize NeuroPlay Studio™ LLC to **release information to** and/or **obtain information from**:

Name/Organization: _____

Address: _____

Phone: _____ **Fax:** _____

Information to be Released

- ☐ Evaluation Report(s)
- ☐ Progress Notes / Treatment Notes
- ☐ Plan of Care / Treatment Plan
- ☐ Discharge Summary
- ☐ School Records / IEP / 504 Plan
- ☐ Medical Records
- ☐ Verbal Communication / Consultation
- ☐ Other: _____

Purpose of Disclosure

- ☐ Continuity of Care / Coordination of Services
- ☐ School Services / Educational Planning
- ☐ Insurance / Billing
- ☐ Legal Purposes
- ☐ Patient/Parent Request
- ☐ Other: _____

Terms of Authorization

I understand that:

- I may revoke this authorization at any time by providing written notice to NeuroPlay Studio™ LLC
- Revocation will not affect any actions taken before the revocation was received
- Information disclosed may be subject to re-disclosure and may no longer be protected by HIPAA
- NeuroPlay Studio™ LLC will not condition treatment on signing this authorization
- I have the right to receive a copy of this authorization

This authorization expires on (date or event):

_____

If no date is specified, this authorization will expire one (1) year from the date signed.

Signatures

_____ _____

Parent/Legal Guardian Signature | Date

_____ _____

Printed Name | Relationship to Patient