THERAPY WORKS, PC

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or a health care provider, the released information may be redisclosed and may no longer be protected by federal privacy regulations.

Patient name:	
Persons/Organizations authorized to release the information:	
Persons/Organizations authorized to receive the information:	**THERAPY WORKS, PC** **1509 Atkinson Rd Suite 1100** **Lawrenceville, GA 30043**
Specific description of information	Any Information that will assist with providing therapies referred for by Primary Care Physician.

The patient or the patient's legal representative must read and initial the following statements:

1. I understand that this authorization will expire upon notice from Parent/Legal Guardian Initials___

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have an effect on any actions taken before the organization received the revocation. Initials_____

Send revocations to: AILEEN DEOGRACIAS, OTR/L
Clinic Director Therapy Works

The purpose of the use or disclosure is: PROVIDE THERAPY SERVICES

- Occupational Therapy/Feeding Therapy
- Speech and Language Therapy
- Physical Therapy

NOTICE TO PATIENT: The patient or the patient's legal representative may inspect and/or copy the protected health information to be disclosed in accordance with Therapy Works, PC's access policies.

Therapy Works, PC does not limit its right to make a use or disclosure of your information that is required by law or permitted to avert a serious threat to the health or safety to the public.

_____ _____
Signature of Patient or Patient's Legal Representative Date

Printed name of Patient's Representative: _____
Relationship to Patient : _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
THERAPY WORKS, PC will not condition treatment or payment on the provision of this authorization.