# Authorization to Exchange/Release/Obtain Protected Health Information

Client's Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

Information of Protected Health Information to be Exchanged/Released/Obtained:

□ All medical, educational, and/or therapy treatment records and information
□ Only specific records noted below:

- □ Speech-Language Pathology evaluation, treatment, progress, and discharge information
- □ Occupational Therapy evaluation, treatment, progress, and discharge information
- □ Physical Therapy evaluation, treatment, progress, and discharge information
- □ Developmental evaluation, treatment, progress, and discharge information
- □ BCBA/ABA evaluation, treatment, progress, and discharge information
- □ Academic/Educational records to include IFSPs and/or IEPs, services, goals, and progress information
- □ Medical records

□ I request the following records **not** be exchanged/released/obtained: _____

I authorize protected health information to be exchanged/released/obtained verbally and/or in writing between the following:

| | |
|---|---|
| Facility Name: Peak Pediatric Therapy, LLC | Facility Name: |
| Point of Contact: Donna Moore, MA, CCC-SLP | Point of Contact(s): |
| Address: 9185 Dome Rock Place<br>Colorado Springs, CO 80924 | Address: |
| Phone: 719-357-5741 | Phone: |
| Fax: 855-370-5735 | Fax: |

I understand I am not required to sign this authorization to receive treatment. I authorize the release and/or use of the client's protected health information in order for agencies to provide the most informed care. I have the right to revoke this authorization at any time by notification in writing, but information previously shared cannot be revoked. Peak Pediatric Therapy, LLC cares about your medical and personal privacy, follows HIPAA regulations, and does everything possible to maintain your privacy. Once released, my information disclosed may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA). I confirm my authorization that Peak Pediatric Therapy, LLC may use and/or disclose to the person(s) and/or agency named in this form the protected health information described in this form, for a period of one year from the date on this form.

Printed Name of Parent/Guardian: _____ Relationship to Client: _____

Signature: _____ Date: _____