Authorization of Medical Records Release

I hereby authorize Capable Therapy, LLC to release or obtain my child's individually identifiable information, including contact information, and information about physical health or mental health, condition, health care or other services, and payment for services, under the circumstances described below. I authorize Capable Therapy, LLC to:

RELEASE written and verbal information to ____

____

OBTAIN written and verbal information from ____

____

Type of Information (specific description, dates): ____

____

I understand that:

• This authorization will expire one year from the date signed, unless an earlier date is provided: ________

• This authorization must be filled out completely to be valid. A copy is as valid as the original. I am entitled to a copy of this authorization.

• Capable Therapy, LLC will not refuse to provide health care services, based on my refusal to authorize the use or disclosure of my personal health information for a purpose unrelated to those health care services.

• I may revoke this authorization at anytime by notifying Capable Therapy, LLC in writing, but if I do, it won't affect any actions Capable Therapy, LLC took in reliance on this authorization before I revoked it.

• Once information is released to a third party according to this authorization, Capable Therapy, LLC cannot prevent its re-disclosure.

• This authorization does not limit the ability of Capable Therapy, LLC to use or disclose my health information as otherwise permitted by state or federal law.

______________________________	______________________________	__________
Patient and Parent/Guardian's Printed Name if Patient is under 18	*Signature*	*Date*