

Therapy Solutions For Kids

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Authorization to use and/or disclose information THIS IS INCLUDES FACSIMILE TRANSMISSION OF INFORMATION

I authorize the following provider (s) to use and/or disclose protected information regarding my child:

Date of Birth:

Name and address of professional authorized to:

***Send/Receive protected health information**

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Therapy Solutions For Kids may communicate with my insurance, primary care facility or any other agency that is affiliated with my child. This may include therapy reports, EI records, school reports, medical records, email and telephone contact. I understand that this is voluntary and I may refuse to sign without it affecting my child's treatment. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization. I may revoke this authorization at any time by contacting the office manager Allie Matthews in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

Signature of parent/guardian/custodial parent

Date

I consent and understand the above information.