Children's Therapy Center, Inc.

CONSENT AND RELEASE EMAIL FORM

Child's Name: _____

DOB: (MM/DD/YYYY) _____

Authorization of Release

I hereby authorize Children's Therapy Center, Inc. (CTC) to release or obtain my individually identifiable information, including contact information, and information about physically health or mental health, condition, health care or other services, and payment for services, under the circumstances described below.

Release: I authorize Children's Therapy Center, Inc

* To release written and verbal information to:_____

* To obtain written and verbal information from:_____

Type of Information: *(specific description of information, including dates)*
(Note: if this authorization is used for psychotherapy notes, it may not be used for any other type of information.)

_____

_____

_____

Note: This information may be disclosed in oral, written, and/or electronic form.

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

I understand that:

- This authorization must be filled out completely to be valid. A copy is as valid as the original.
- CTC will not refuse to provide health care services to me, 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 CTC in writing, but if I do, it won't affect any actions CTC took in reliance on this authorization before I revoked it.
- Once information is released to a third party according to this authorization, CTC can not prevent its re-disclosure.
- This authorization does not limit the ability of CTC to use or disclose my health information as otherwise permitted by state or federal law.

Print Parent/Legal Guardian's Name: _____

Describe Relationship to Patient: _____

Parent/Legal Guardian's Signature:_____

By entering your complete name and emailing this form it will be considered signed by you.

You may be asked to sign the form in person on your first visit. Thank you for your cooperation.

Date: (MM/DD/YYYY) _____

(You are entitled to a copy of this authorization form)

You may email completed forms to: info@childrenstherapyctr.com
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14635 Pennock Ave. # 300, Apple Valley, MN 55124 Ph: (952) 997-2823 Fax: (952) 997-6931
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