Children's Therapy Center, Inc.

childrenstherapyctr.com

Eagan, MN
(p) 651-994-9644
(f) 651-994-8962
Apple Valley, MN
(p) 952-997-2823
(f) 952-997-6931

Consent and Release Form

Patient Name: _____ DOB: _____

Authorization of Release

I hereby authorize 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.

I authorize Children's Therapy Center, Inc.

☐ to release information to:
☐ to obtain information from:

Name of Person and/or Organization:_____ Fax#:_____

Address: _____

_____
City State Zip

Type of Information to be released/obtained:

☐ All Information ☐ Progress Notes ☐ Health Record
☐ Evaluation Reports ☐ Discharge Summary
☐ Other (please specify): _____

*If applicable, include dates information is being requested: From ____/____/_____ to ____/____/_____

Purpose of Information:

☐ Coordination of Care ☐ Personal use/review ☐ Litigation/legal
☐ Insurance payment/claim
☐ Other (please specify): _____

Note: This information may be disclosed in oral or written form

This authorization will continue forever unless you cancel it by writing to us at: Children's Therapy Center, Inc., 2795 Pilot Knob Rd, Eagan, MN 55121: but if the consent is cancelled, it will not change releases that have already been made.

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: _____ **Date:** _____

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