



*Journeys*  
Occupational Therapy LLC

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**HIPAA Consent to Use and Disclose Health Information**

By signing this form, I acknowledge that I have received a copy of Journeys Occupational Therapy LLC's Notice of Privacy Practices.

-I request the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Printed Name: \_\_\_\_\_

Client Date of Birth: \_\_\_\_\_

Client Name if signing for a minor child: \_\_\_\_\_

It has been our experience that some clients prefer email correspondence regarding their own or their child's care. Journeys Occupational Therapy, LLC, does NOT have HIPAA-compliant (encrypted) email service. With this understanding, please initial:

\_\_\_ I give my permission to correspond by email regarding my/my child's care.

\_\_\_ I prefer phone correspondence only. These may or may not include text messages.

If we are unable to speak with you directly by phone, is it okay for us to leave detailed/clinical information and/or appointment reminders on your answering machine, if available?

\_\_\_ Yes    \_\_\_ No    \_\_\_ Appointment reminders only

**Release of Information (OPTIONAL)**

I authorize Journeys Occupational Therapy, LLC to release and/or discuss medical/healthcare information with:

\_\_\_ My Physician in order to obtain a script for services (please initial)

\_\_\_ My insurance company in order to submit claims. (please initial)

The following individuals or facilities, in order to coordinate care:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Signature:** \_\_\_\_\_