Journeys
Occupational Therapy

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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:_____