Honeybee Pediatric Therapy, LLC

AUTHORIZATION TO RELEASE AND/OR OBTAIN HEALTHCARE INFORMATION

I authorize and/or request Honeybee Pediatric Therapy, LLC to receive or disclose protected health information from the records of:

CLIENT NAME	
DATE OF BIRTH	

To/From:

AGENCY/ORGANIZATION/PERSON	
ADDRESS/FAX	
PHONE	

You are authorized to disclose/receive and discuss the following:

	ANY INFORMATION RELATED TO THE CLIENTS CARE AND TREATMENT BY PROVIDER
	LATEST WELL-CHILD CHECK UP
	PROGRESS REPORTS
	IEP/IFSP RECORDS
	EVALUATIONS
	SCREENING RESULTS
	DIAGNOSTIC REPORTS
	BEHAVIOR PLANS
	OTHER:

Purpose of disclosures:

	Insurance coverage and/or payment of care
	Delivery of therapy services
	Coordination of care
	Other:

I understand Maine law requires specific consent must be given to disclose the following information:

I DO	I DO NOT	
		Authorize disclosure of information which refers to the treatment and or diagnosis of drug or alcohol abuse.
		Authorize disclosure of information which refers to treatment or diagnosis of mental health issues.
		Want to review mental health information before it is released. I understand that my review must be supervised.
		Authorize release of information regarding the diagnosis or treatment of HIV, ARC, or AIDS

I understand that:
-Information may be exchanged by mail, fax, electronic communication, telephone, or other appropriate means.
-A copy of this authorization can be relied upon as if it were the original.
-I can revoke all or part of this authorization at any time by notifying Honeybee Pediatric Therapy in writing, as provided for in our notices of privacy practices, subject to the rights of anyone who received and or disclose information prior to receiving the revocation.
-I can choose to disclose all or some of the information in my healthcare records.
-A refusal to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage/payment or other adverse consequences.
-If this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization that receives that information.
-I am entitled to a copy of this authorization form if requested.
-This authorization is valid for a period of one year from the date of signing.

Signature of Parent/Guardian Relationship To the Client Date

28 Winter Place, Suite 4, Norway, ME 04268
Phone: (207) 739-2021 Fax (207) 739-2188