



Pediatric Occupational Therapy Services

Direct Line: (803) 329-9500

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HIPPA Compliance

CONSENT TO DISCUSS WITH FAMILY MEMBER(S) AND/OR PERSONAL REPRESENTATIVE AUTHORIZATION FOR TREATMENT AND/OR FINANCIAL INFORMATION IN THE PATIENTS ABSENCE.

I hereby give my permission for *Therapy World, LLC* therapist and other staff, including clerical, to disclose and discuss my medical and financial information with the following individual(s):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient/Guarantor Signature: _____ Date: _____

Witness Signature: _____ Date: _____

I, _____ give permission for *Therapy World, LLC* to disclose protected Health Information in the form of:

Please mark all that apply:

May Leave DETAILED messages via answering machine, email, or letter.

In person with myself and authorized individual(s) as indicated above.

I have been provided a copy of *Therapy World, LLC* Notice of Privacy Practices, version effective January 10, 2018. I consent to the uses and disclosures of my protected health information as outlined in the Notice of Privacy Practices.

Signature of Patient or Guardian

Date

Print Name of Patient

Print Name of Guardian (if applicable)