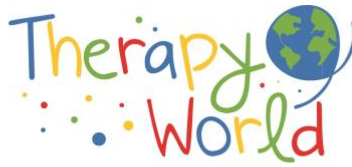

Pediatric Therapy Services
Direct Line: (803) 329-9500 Email: support@mytherapyworld.com

HIPPA Compliance

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

____
Name of Patient (PRINT)

____
Print Name of Guardian