Achieve Therapy Services

Pediatric Therapy
Physical
Occupational
Speech

Authorization For Release of Protected Health Information

- Medical records are to include any and all Federal and State protected information without limitation to include diagnosis, treatment and/or examination related to mental health related care, drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmitted diseases.

- By signing this release, you understand that this authorization will remain in effect until revoked in writing. **Achieve Therapy Services, LLC** is authorized to use outside vendors for the purpose of copying and providing the information requested.

- I understand that the state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that **Achieve Therapy Services, LLC** cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

- I understand that I have the right to inspect and obtain a copy of any information disclosed by **Achieve Therapy Services, LLC**.

- I hereby release **Achieve Therapy Services, LLC** and its employees from any and all liability that may arise from the release of information as I have directed.

- I understand that if I have requested duplication of records within a one year time period (of the same or similar records), I may be charged a fee of up to $1.00 per page for every page copied. This fee may be waived for copies provided to a health care provider, insurance company or other specific organizations for treatment, billing, or operations purposes.

Records to be released to: _____

Address: _____

_____

Phone: (___) _____Fax: (___) _____

Patient's Full Name: _____ DOB: ___/___/___
(Please print clearly)

Signature of Patient: _____ Date: ___/___/___
or Empowered Representative
(Must provide POA or supporting documentation for personal representative/healthcare surrogate)

***A photo ID must be provided for proof of identity or release must be notarized.**

Checked by: _____
Relationship to Patient: _____
Witness: _____ Date: ___/___/____

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