REDWOOD THERAPY

HIPAA AUTHORIZATION FORM

Client's Full Name _____ **Client's Date of Birth** _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   Redwood Therapy, LLC, and Kristen O'Hern, MOTR/L
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   Redwood Therapy, LLC and Kristen O'Hern, MOTR/L
3. The specific information that should be disclosed is (please give dates of service if possible):

   _____

4. _____I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. _____I may revoke this authorization by notifying **Redwood Therapy, LLC** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. _____My purpose/use of the information is for continued healthcare services related to increasing my independence and/or developing skills that increase my eligibility for gainful employment in the community.
7. _____This authorization expires on_____, OR upon occurrence of discharge from the services of Redwood Therapy, LLC and/or a written request provided by me to end this authorization.

8. Please call _____ My Home _____My Cell Phone _____My Work _____Other Phone

9. Please leave _____ A detailed message _____A request to return the call

10. _____I authorize the above listed parties to use email to contact me. *Please use email for:*

    _____*Detailed information* _____ *requesting that I contact you at my earliest convenience*

11. _____I understand that information can and will be shared with any payor source, including private insurance and/or the state of Arizona's Department of Economic Services Vocational Rehabilitation.

_____ _____ _____
Signature of Client **Date** **Date of Birth**

_____ _____ _____
Signature of Client's Guardian **Date** **Relationship to Client**


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THERAPY