Reach for the Top
Therapy Services

The McConnell Center
61 Locust Street • Suite 331
Dover, NH 03820

Phone: 603-740-3534
Fax: 603-740-3684

Authorization for use or disclosure of protected Health Information

Patient: ______________________________ **DOB:** ______________

I, ______________________________, the parent/guardian (circle one), authorize Reach for the Top Therapy Services to:

☐ **Receive** medical and other information from: ☐ **Release** medical and other information to:

Name / Organization: ______________________________

Address: ______________________ City / State: ______________ Zip Code: ____________

Phone: ______________________ Fax: ______________________

■ Treatment dates to be disclosed: ______________________________

■ Purpose of the disclosure: Coordination of Care ☐Other: ______________________________

■ Specific description of the information to be disclosed:

☐Evaluations ☐Progress Reports ☐Test Results ☐IEP / IFSP ☐School records

☐Physical/Medical records ☐Behavioral Health records

☐Other: ______________________________

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under State laws and Federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protections Rules. I understand I have the right to revoke this authorization at any time and that my revocation needs to be submitted in writing to Reach for the Top Therapy Services. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment.

I hereby authorize Reach for the Top Therapy Services to disclose/release medical records and other information obtained during my treatment. **Unless revoked, this consent will expire 1 year from the date signed or upon discharge.**

______________________________ ______________________________ ______________

Print Name (Parent/Guardian) Signature (Parent/Guardian) Date Signed