



Authorization Form

Consent for Use and Disclosure of Protected Health Information

Client's Name: _____ DOB: _____

I hereby authorize Advantis Therapy, LLC to use or disclose the above-named client's protected health information.

1. Persons or groups authorized to receive this information:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

2. Information to be used or disclosed: (Please check all that apply)

- Initial Report
- Care Plan/ Progress Notes
- Assessment Scores
- None of the above

3. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal law.

4. I understand I have the right to revoke this authorization in writing at any time, except to the extent information has already been released pursuant to this authorization at the time of the revocation.

5. I hereby release, discharge and agree to hold Advantis Therapy, LLC harmless from any liability that may arise from the release of information authorized above.

This authorization will expire one year from the date of signature or less than a year as indicated: _____

Client or Representative Signature

Date

Name or Personal Representative (Print)

Relationship to Client