Developing Connections™
Speech & Occupational Therapy

14145 Simone Drive, Shelby Township, MI 48315

Phone: 586-566-6280 Fax: 586-566-1898

Authority To Obtain and Disclosure Information

Regarding Client

Name: ____ **Birthdate**________________________________

Address: ____

City/State/Zip: ____

Information Requested and Purpose

____

____

____

☐ **Authority To Obtain Confidential Information: I give express authority to the organization named below to release Developing Connections any confidential pertinent requested information concerning the above-named individual. Once the information is received, it may become part of the individual's record.**

Organizations Name____

☐ **Authority To Release Confidential Information FROM Clinic. I give express authority to developing Connections, to release any pertinent information concerning the above-named individual to:**

School Name____

School Address____

☐ **Health information used or disclosed based on this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPPA's Privacy Rules.**

☐ **I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to Developing Connections Inc. I further understand that the clinic may have already released the information based on my original authorization. However, the clinic will not release any additional information after receiving my revocation.**

Signature (Parent/Guardian/Adult Student/Legal Representative) ____

Relationship____**Date:** ___________________________________

Acknowledged Receipt of Authorization Form: ____