Authorization/Release of Information

Patient Name: _______________________________________ DOB:___________________

Name of Parent(s) or Legal Guardian: ____

REFERRING PHYSICIAN

In order to insure proper documentation for insurance carriers and Georgia Medicaid, *Dynamic Pediatric Speech Therapy, LLC (DPST)* will release your child's discipline specific plan of care (PT, OT, ST) to your child's primary care physician (pediatrician) every six months in order to obtain his/her signature and continued prescription of services.

Primary Care Physician: ________________________________ Phone: __________________________

Practice Name: _______________________________________ Office Location (City): __________________

SPECIALISTS

In order to provide the best possible care for your child, it is often necessary for *DPST* therapists to consult with your child's specialists. Please list any specialists with whom we have your expressed permission to share information about your child's treatment in the spaces below.

Physician: _______________________________________ Phone:________________________________

Practice Name: ___________________________________ Specialty: _____________________________

Physician: _______________________________________ Phone: _______________________________

Practice Name: ___________________________________ Specialty: _____________________________

Physician: _______________________________________ Phone: _______________________________

Practice Name: ___________________________________ Specialty: _____________________________

EDUCATIONAL PERSONNEL

School-based therapists and teachers may wish to discuss your child's treatment, goals, and/or exchange information in order to maximize your child's success. By listing your child's educational institution, you grant permission for *DPST* therapists and representatives to exchange information with your child's classroom teacher, support staff, and school-based therapists (PT, OT, ST).

School Name: ____________________________________ County: _______________________________

OTHERS APPROVED TO RECEIVE INFORMATION:

____________________________________ ____

NAME/RELATIONSHIP TO PATIENT NAME/RELATIONSHIP TO PATIENT

____________________________________ ____

NAME/RELATIONSHIP TO PATIENT NAME/RELATIONSHIP TO PATIENT

This authorization shall remain in effect for a period of no less than one year from date signed. You may revoke this authorization at any time by notifying your child's therapist or other *Dynamic Pediatric Speech Therapy, LLC* representative in writing.

Signature of Parent/Legal Guardian: ____________________________ Date: _______________________

CONSENT TO CORRESPOND ELECTRONICALLY

DPST, LLC understands the importance of efficient communication and rapid delivery of your child's medical records when requested for insurance and Medicaid renewals. While *DPST, LLC* takes all reasonable precautions to protect your child's health information; we also acknowledge that email is not a completely secure method of communication and document delivery.

I acknowledge that by initiating contact via email with a DPST, LLC therapist and/or representative in regards to my child's care, the therapist and/or representative has my permission to reply/correspond via that email address.

In addition, I give permission for a DPST, LLC therapist or representative to email me at the following email address(es) in order to discuss my child's treatment, answer questions, discuss scheduling changes, and/or to provide requested medical documentation via attachments:

Email Address: ____

Email Address: ____

____ Date: _________________________
Signature of Parent of Legal Guardian

CONSENT TO PHOTOGRAPH

I authorize my child's therapist(s) to photograph/videotape my child in order to document my child's status and progress for the justification of treatment. Said photographic documentation is considered PHI and will only be released to those individuals with whom you have given expressed permission to share information about your child's treatment, except as required by law as documented in the Notice of Privacy Practices.

____ Date: _________________________
Signature of Parent or Legal Guardian