Children's Therapy Associates, Inc.

Confidentiality Form

In accordance with the Health Insurance Protability & Accountability Act of 1996 (a Federal Law).

It is the office policy of Children's Therapy Associates, Inc. and staff to not release confidential and / or unauthorized information. When returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you require HealthCare information to be released to someone other than yourself please complete the following:

I authorize Children's Therapy Associates and / or staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

May we reach you at home?	☐ Yes	☐ No
May we confirm your appointments by answering machine?	☐ Yes	☐ No
If you are employed may we contact you at work?	☐ Yes	☐ No
May we leave a message for you at work?	☐ Yes	☐ No

It is important to keep your other physicians informed about your care.
If needed may Children's Therapy Associates release medical records to your other physicians? ☐ Yes ☐ No

Please list names of authorized people:

Spouse _____

Parent(s) _____

Other Person _____

(Relationship) _____

Do you have a Power of Attorney? ☐ Yes ☐ No
If Yes, please supply a copy to our office.

Patient: _____ Date _____

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