EARLY CHILDHOOD

Wellness place

520 Zang Street, Ste 212; Broomfield, CO 80021 • (720) 593-0018

Authorization to Release Information

I, ________________________________, authorize the mutual exchange of information
(client's/parent's name)

between Jessica Franco, OTR/L and ___________________________________.
(name of person or organization)

Information to be released includes: (check boxes)

☐ Social History ☐ Legal History
☐ Reports or Evaluations ☐ Treatment Goals
☐ Medical History ☐ Other ______________________
☐ Protected Health Information (if checked, this must be a consent for release of PHI only)

Information is released for the purpose of: (check boxes)

☐ Continuity of Care ☐ Assessment
☐ Service Planning ☐ Legal Purposes
☐ Other ____.

I understand that my records are protected under specific federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it (e.g. the provision of treatment upon consent to disclosure to third party players) and that in any event this consent expires automatically as described below.

This authorization of exchange of information is valid for one year from date of signature.

I understand that information used of disclosed pursuant to this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by the HIPPA privacy rule.

I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Printed name: __________________________________

Signature: ______________________________________ Date: _____________

Therapist's Signature: ____________________________ Date: _____________

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Consent for the Treatment of a Minor

I, ___________________________________, hereby authorize Jessica Franco, OTR/L, to

provide occupational therapy services to _______________________________________.

(child's name)

I attest that I am the sole/joint (please circle one) legal guardian of the above stated child and am legally and financially responsible for the above stated child. In the case of joint custody, both legal guardians are required to sign this consent form before a minor child can be seen in therapy. *When parents are divorced, Colorado law allows any parent who has been assigned parental responsibilities access to medical records. Therefore, in compliance with C.R.S. §14-10-123.8, you authorize me to provide access to treatment information to such an individual by authorizing me to provide services to a child in your custody.* **Legal documentation of the custody/guardianship agreement is needed at the time of signing this consent form and before the minor child is seen in therapy.**

____ ___________________________

Signature of parent or legal guardian Date

____ ___________________________

Signature of parent or legal guardian (for joint custody) Date

____ ___________________________

Signature of therapist (*indicating that legal documentation has been received*) Date