Comprehensive Therapy Services

Speech Therapy • Occupational Therapy • Physical Therapy

Patient Name: _____
Medicaid Insurance ID #: _____

Due to HIPAA regulations, CTS is not able to give out any confidential patient information to individuals, other than the parent or guardian, who may bring the child to therapy. If you will have anyone besides yourself bring your child to therapy at any time (grandparent, babysitter, nanny etc.) please complete the information below so that the therapist may relay health information about your child to the person who brings him/her to therapy.

Patient Name: _____

Date of Birth: _____

I, _____, give permission for

Parent/Guardian

Comprehensive Therapy Services to disclose protected health information regarding

_____ To _____

Patient Name **Caregiver**

_____ (√) Parent/Guardian will be bringing the child to therapy.

Expiration or Termination of Authorization: This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Contact. This can be done in person or by mailing a request to the address below.

_____ _____

Parent or Guardian Signature **Date**

2201 N. Central Expressway, Suite 110 Richardson, TX 75080
Phone 214-265-1819 ● Fax 214-373-9530