HIPAA AUTHORIZATION FORM

Health Insurance Portability and Accountability Act

I, _____, give permission to Allison Therapeutics, LLC to Receive and Disclose evaluation and progress reports including protected health information regarding _____ from/to:

1. Primary MD:_____
2. Insurance: _____
3. School: _____

[Name(s) of entity to receive information]

Information to be disclosed includes (check all that apply):

- ❑ Medical Records
- ❑ Treatment Records
- ❑ Diagnostic Records
- ❑ School Records
- ❑ Other:_____

This protected information is being used or disclosed for to achieve Interdisciplinary collaboration and to provide services which consider the whole child and his/her functional needs.

This authorization expires:

- ❑ Upon discharge from therapy
- ❑ Date: _____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization.

Finally you may revoke this authorization in writing at any time by sending written notification to Jennifer Reidenbach at Allison Therapeutics LLC, 1233 Ben Sawyer Blvd, Suite 500, Mount Pleasant, South Carolina 29464. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____ _____

Signature of Participant or Personal Representative / Date

Printed Name of Participant or Personal Representative