1/2013

Southland Therapy Services, Inc.
PO Box 30606
Savannah, GA 31410
Phone: (912) 335-1650

Consent to Release and/or Obtain Information

Patient Name: ____ **Date of Birth**:____________

Parent / Guardian Name: _________________________________

My signature on this form indicates that I (parent or legal representative)

- Authorize the contracted therapists and company representatives to disclose and / or obtain specific health / medical and educational information from the records of the above named child
- Understand that I may request a copy of any information that is disclosed or obtained
- Agree that a copy of this consent may be treated as an original
- Understand that if the record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, or genetic testing this disclosure may include that information
- Understand that this information may be released in any of the following ways: fax, email, direct mail, wireless communication or by telephone
- Understand that, while services will not be denied because of failure to sign this consent form, inability to collect necessary information may cause denial of eligibility for Therapy Services with Southland Therapy Services, Inc.
- Grant consent from the date I sign the consent until discharge of the patient from Southland Therapy Services, Inc.
- I authorize Southland Therapy Services, Inc. to use and/or disclose my protected health information to physicians, payers of health care services and other heath care providers to help provide appropriate treatment for my child.

_______________________________________ ____________________

Parent or Legal Representative Signature **Date**

NOTICE OF PRIVACY PRACTICES

By law, we are required to provide you with our **Notice of Privacy Practices (NPP)**. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.
As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice should you desire.

We want to assure you that your medical / protected health information is secure with us. This Notice contains information about how we will insure that your information remains private. If you have any questions about this notice, contact the name as listed and the phone number on this page: Dawn Kearney

Acknowledgement of Notice of Privacy Practices

"This acknowledges that I have received a copy of this practice's **Notice of Privacy Practices**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer the updates to this **Notice of Privacy Practices** should it be amended.

Patient Name:____ **Date**:________________________

Parent or Legal Representative Signature:____