

Patient Notification of Privacy Policies

THIS NOTICE DESCRIBES HOW YOUR MEDICAL RECORDS MAY BE USED OR DISCLOSED AND HOW YOU CAN ACCESS YOUR RECORDS. PLEASE REVIEW IT CAREFULLY.

I hereby authorize use or disclosure of protected health information about my child as described below:

1. Confidential information is stored in a secure location away from public access. All computers containing confidential information are only accessed by password.
2. Theraplay is authorized to disclose pertinent health information to insurance companies or referring physicians for the purposes of requesting doctor's orders, authorization for service or to obtain reimbursement for services. Information may be sent via first class mail or fax with procedures in place to limit the likelihood of unauthorized access.
3. Theraplay and its employees are authorized to use or disclose pertinent health information that is required for speech-language therapy and occupational therapy purposes.
4. Theraplay may disclose protected health information considered pertinent to speech-language therapy and occupational therapy to specified professionals (i.e. social workers, teachers, psychologists, physicians, therapist, etc.) with a signed release form from the parent or guardian.
5. Your mobile phone number will only be used for healthcare-related communications and will not be shared with third parties for their marketing purposes. You may opt-out of receiving SMS communications at any time. To opt-out, reply "STOP" to any message you receive from us or contact our office directly.
6. I, the parent/guardian, may revoke this authorization by notifying Theraplay in writing of my desire to revoke it. However, I understand that any action already completed prior to the request to revoke this authorization cannot be reversed, and my revocation will not affect those actions.
7. This authorization expires when the client is discharged from therapy, although the Company will always use professional discretion when sharing any public health information.

I, _____ (parent/guardian name):

- Understand and agree that Theraplay uses video recording for therapy and parent education purposes. These recordings will not be used for any other purposes.
- Consent to my child's image being used for marketing purposes.

Parent/Guardian Signature

Date

Parent/Guardian's Printed Name

Child's Name

*If you have any questions or concerns, please contact our Privacy Officer, Jeanine Morton at (919) 774-1281