



Developmental Therapy Associates, Inc.

3514 University Drive, Office #8 – Durham, NC 27707
(919) 493-7002 – Fax (919) 403-1407

3500 Regency Parkway, Suite 120 – Cary, NC 27518
(919) 465-3966 – Fax (919) 465-3886

www.developmentaltherapy.com

AUTHORIZATION FORM

I authorize Developmental Therapy Associates and _____

Phone: _____ Fax: _____

to exchange **Protected Health Information** from the medical/clinical record of:

Client Name: _____ DOB: _____

I understand that the federal privacy law protecting health information may not apply to the recipient of the information and therefore, may not prohibit the recipient from redisclosing it.

I understand what information will be released, the purpose for the release of the information, and that there are statutes and regulations protecting the confidentiality of the information. DTA’s NOTICE OF PRIVACY PRACTICES describes the circumstances where disclosure is permitted or required by state or federal laws.

I understand the terms of the Authorization for Disclosure and voluntarily give my authorization.

I understand that I may refuse to sign this authorization form. DTA will not condition my evaluation or treatment on receiving my signature on this authorization. I further understand that I may revoke this authorization by written request at any time. Such revocation does not affect the validity of my authorization for information disclosed/released prior to revocation. If not revoked earlier, this authorization expires automatically on _____ or one year from the date it is signed, whichever is earlier.

Print name of signer: _____

Signature: _____ Date: _____

(Specify if signature is client, parent, or legal guardian)