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 FOR DISCLOSURE

Client Name: _____ DOB: _____

I hereby authorize the release of information **TO** Developmental Therapy Associates (DTA) **FROM** the following person and/or agency for the purposes of assessment, treatment planning, and/or coordination of services:

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

Please INITIAL on the list below which information regarding your treatment may be released and/or exchanged between the noted agencies. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

____Evaluation Report ____Treatment Notes
____Discharge Summary ____Other (Specify)_____
____I authorize periodic exchange of relevant clinical information.

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.

Signed: _____ Date: _____
(Specify if signature is client's, parent's, or legal guardian's.)