talk&play
ASSOCIATES

PATIENT INFORMATION		
Patient's Name:	Birthdate:	Sex: ☐ M ☐ F

I hereby authorize Talk & Play Associates and any of their affiliated entities, employees, agents, and associated health care practitioners to use or disclose the patient's protected health information as described below.

1. Talk & Play Associates may use or disclose information relating to the patient's care during the following relevant time period:
   - ☐ All past, present and future dates
   - ☐ From _____ to _____.
2. I authorize Talk & Play Associates to release information to the following entities:
   - ☐ Physicians: _____
   - ☐ School District: _____
   - ☐ Other: _____

STATEMENT OF UNDERSTANDING

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Talk & Play Associates. I understand that the evocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that unless I revoke this authorization as stated above, this authorization will expire at discharge date unless I have specified a different date of expiration. I understand that the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment from Talk & Play Associates. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the re-disclosure may not be protected by federal confidentiality rules. I have a right to limit the information disclosed.

_____ _____

Parent/Guardian Signature **Date**