3119 Lithia Pinecrest Rd *Valrico, FL 33596
Phone (813) 662-1106 * Fax 813-661-7661

Kid's Therapy Unlimited, Inc. is hereby authorized to:
( ) Release or Copy ( ) Receive ( ) Permitted the inspection of listed records/information

To/By: ________________________________ Address: ________________________________
Agency Name Agency Address

Regarding: ____ DOB: ____________________

Parent/Guardian: ____

Check all that applies to be released/copied/inspected:
( ) Psychological Information
( ) Diagnostic Information
( ) Social/Developmental Information
( ) Attendance Information
( ) Health/Medical/Birth Information
( ) Educational Information
( ) Therapy Records (Occupational, Physical, Speech)
( ) Other:
____

Please send information to Kid's Therapy Unlimited, Inc. in care of the above address.

The person or agency receiving these records must not transfer the information obtained to any other person or agency without obtaining the written consent of the parent or legal guardian, or student if eighteen years of age or older.

Pursuant to Public Law 93-380, you are hereby notified that you have the right to inspect educational records, to have a copy of said records if you wish to pay the cost of duplication, and to challenge the content of said records on the grounds that they may be inaccurate, misleading or inappropriate.

This shall be effective 365 days from the date of signing.

Based on the HIPPA Privacy Law, I understand I have the right to revoke this authorization, in writing, at any time. I understand I must present my written revocation to Kid's Therapy Unlimited, Inc. with it signed and dated. I understand that the revocation will not apply to information that has already been released to this authorization.

Please check one of the following:

_____ I certify that I am over the age of eighteen and I am the person who is the subject matter of the records listed above.

_____ I certify that I am the parent or legal guardian of the person who is the subject matter of the records listed above, and that said person in under the age of eighteen. I understand that the information and/or reports that are shared with Kid's Therapy Unlimited, Inc.may become part of the child's medical file.

______________________________________ ______________________

Printed Name of Parent/Guardian/Self Date

____

Signature of Parent/Guardian/Self