HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH RECORDS

Patient Name:

DOB:

I hereby authorize the use and disclosure of protected health information as described below;

Identify those one or more persons/organizations ("Covered Entity" whether one or more) authorized to use or DISCLOSE or Receive your information:

Identify those persons/organizations authorized to Disclose or Receive your information:

Cross River Therapy
2530 Meridian Parkway Suite 300, Durham, NC 27713, 27713
P. 919-375-0475
F. 919-928-5528

The release of my records is for continuation of care. This document is to expire in (six) 6 months from date of signature.

Parent or Guardian Signature: _____

Date: _____