Kidsplay Therapy Center, Inc.

Patient Privacy Information

I hereby authorize Kidsplay Therapy Center, Inc. and staff to leave medical information pertaining to my child's care by the following methods and will assume responsibility to notify them whenever this information changes.

HOME#	CELL#	WORK#	EMAIL

Kidsplay Therapy Center will only leave a message on your answering machine with your permission. May we leave a message on your answering machine? Yes_____ No_____

I hereby authorize Kidsplay Therapy Center and staff to fax or mail medical information pertaining to my child's care to a referred or referring healthcare provider and will assume responsibility to notify them whenever this information changes.

Kidsplay Therapy Center may talk to whomever brings your child or guardian to therapy about their care and therapy unless you enter their name in the lines below:

Notice of Privacy Practices

I acknowledge that I have been provided an opportunity to have a copy of the Notice of Privacy Practices from Kidsplay Therapy Center for me to keep and that I have read (or had the opportunity to read if I so chose) and understood the Notice. This acknowledgement is requested per government statute.

_____

Patient Name (please print)

_____

Parent or Guardian Name (please print) Relationship to Patient

_____

Signature Date