Sensory KIDS, LLC
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GLOBAL RELEASE OF INFORMATION FORM

I hereby authorize Sensory KIDS, LLC to disclose my individually identifiable health information to the organization and/or provider below. I understand that this authorization is voluntary and that if the recipient of this authorization is not a covered entity (e.g. non-health care provider), the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire within **1 year** from the date of signature. Furthermore, I understand that I may revoke this authorization at any time by notifying Sensory KIDS, LLC with a signed and dated written request. In doing so, however, the revocation will not affect any releases made prior to the receipt of the written revocation.

I understand that there is no charge for records provided on electronic media, however there may be a charge for hard copies that are 25 pages or more in length.

☐ By checking this box, I would like to review my/my child's record

Please check all categories of information that you would like to be released to the below provider and/or organization in question:

☐ **Daily Notes** ☐ **Determinations** ☐ **Evaluations** ☐ **Progress Summaries**
☐ **Billing Records** ☐ **Complete Chart**

☐ By checking this box, I authorize Sensory KIDS to release and share information through a phone/remote consultation with the provider and/or organization in question. I understand that this information will include, but not be limited to therapy sessions, medical records, and factual information regarding myself and/or my family member(s).

Patient information:

Patient Name:	Patient Date of Birth:
Name of Authorizing Individual:	Relation to Patient:

The information will be released to:

Organization/Individual Name:	
Address (Street, City, State, Zip):	
Fax Number:	Phone Number:
Email:	

Purpose of this disclosure: ☐ Coordination of Care ☐ Legal ☐ Insurance ☐ Personal
☐ Other: _____

If there has been a recent visit, I understand that the record might not be complete and additional documentation could be added after submitting this request. I understand that a photocopy of this release is as effective as the original.

Signature of Patient or Legal Representative Date

Printed Name of Legal Representative