Play2Grow
Developmental Therapy Services

8050 SW Warm Springs St. Suite 130 Tualatin Oregon 97062

AUTHORIZATION TO REQUEST OR DISCLOSE PROTECTED HEALTH INFORMATION

Completion of this form will serve as written permission for the Play to Grow providers that you indicate to communicate with the individuals you list below, only in the manner you specify. This authorization will be considered valid throughout the course of treatment unless otherwise requested by the patient and/or guardian(s).

Patient Name: ______________________________________ **Date of Birth:** ________________________

I authorize release of information to and between Play to Grow Developmental Therapy and its associated therapy providers:

☐ **Play to Grow Developmental Therapy LLC**
Deborah Ferguson MHS OTR/L
Occupational and Speech Therapies
503-564-0565
deborah@weplay2grow.com

☐ **DLH Occupational Therapy Services**
Donna Hamilton MOT OTR/L
Occupational Therapy
503-564-0565
donna@weplay2grow.com

☐ **Carol Markovics LLC**
Carol Markovics PhD
Clinical and Developmental Psychology
503-564-0565
dr.carol@me.com

And the following individuals:

Name and Relationship or Title	Contact Information	Shared Information May Include:
______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________	____________________________________ ____________________________________ ____________________________________ ____________________________________ ____________________________________ ____________________________________ ____________________________________	☐ **No restrictions**, all information relevant/pertinent to coordinating patient treatment ***- OR -*** ☐ Session notes only ☐ Evaluation reports only ☐ Informal progress updates only ☐ Other: __________________ __________________________

Name and Relationship or Title	Contact Information	Shared Information May Include:
______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________	____________________________________ ____________________________________ ____________________________________ ____________________________________ ____________________________________ ____________________________________ ____________________________________	☐ **No restrictions**, all information relevant/pertinent to coordinating patient treatment ***- OR -*** ☐ Session notes only ☐ Evaluation reports only ☐ Informal progress updates only ☐ Other: __________________ __________________________

Name and Relationship or Title	Contact Information	Shared Information May Include:
____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________	________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________ ________________________________	☐ **No restrictions**, all information relevant/pertinent to coordinating patient treatment ***- OR -*** ☐ Session notes only ☐ Evaluation reports only ☐ Informal progress updates only ☐ Other: ________________ _________________________

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Communication to/from these individuals may occur in a variety of ways (in person, phone, email, fax, etc.). Please know that you have the right to restrict how information about you or your child is shared. Kindly indicate any restrictions you wish to request regarding how information about you or your child is shared with the above named individuals:

☐ I do not have any restrictions on how information is shared.

☐ I wish to apply the following restrictions (i.e., phone calls only, no emails, etc.): ______________________________

____

Patient/Guardian Signature: ____ **Date:** ______________________

Printed Name/Relationship to patient: ____