OCCUPATIONAL THERAPY CONNECTIONS LLC
6801 LAKE PLAZA DRIVE, SUITE A101a
INDIANAPOLIS, IN 46220
(317) 581-1185 Fax (317) 581-1355

AUTHORIZATION for EXCHANGE OF CONFIDENTIAL INFORMATION

This form when completed and signed by you, authorizes this clinic to release protected information from your clinical record to the person or organization you designate. Signing this authorization is voluntary. If the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

_____	_____
Name of Patient	Organization/Person to Exchange Information
_____	_____
Date of Birth	Phone Number:
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip	City, State, Zip

I hereby authorize: Occupational Therapy Connections LLC
6801 Lake Plaza Drive, Suite A101a
Indianapolis, IN 46220
(317) 581-1185
Fax: (317) 581-1355

and the organization or person designated above to exchange the following information

_____

for the following purpose: _____

I understand that my treatment and the payment for my healthcare will not be conditioned by whether I sign this authorization. I understand that I may revoke this request in writing at any time and that my revocation will not affect any actions taken before notice of revocation.

This authorization shall remain in effect until __/__/__ (D/M/YR) or until _____

_____

Signature of Patient/ Parent/Guardian Date

_____

Printed Name of Patient/Parent/Guardian

_____

Relationship to Patient