Step Forward Therapy Ltd.

3350 W. Salt Creek Lane, Suite 115
Arlington Heights, IL 60005
Ph: 224-248-9449

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Section A: Client complete for all authorizations. Please check and initial statement(s) that applies.
[ ] I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations. Initials: _______________

[ ] I hereby authorize Step Forward Therapy Ltd. to obtain individually identifiable health information as described below. I understand that this authorization is voluntary. Information obtained will be for the sole use of Step Forward Therapy Ltd. to provide treatment, receive payment or for health care operations purposes. Initials: _______________

Client Name: ____ **Date of Birth:** _____________________

Step Forward Therapy, Ltd. may release to or obtain from as indicated below (physician(s), healthcare providers, educational program(s), or other agencies) my health information.
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Name, Address, Phone, Fax
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Name, Address, Phone, Fax
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Name, Address, Phone, Fax

Description of information to be disclosed or obtained: [ ] Evaluation/Assessment [ ] Progress Notes/Summary [ ] Medical History [ ] Discharge Reports [ ] Psychological Reports [ ] IEP/School Records [ ] Medical Consultation [ ] Physical/Immunization Records [ ] Other as here specified
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Client or the Client's representative read and initial the following statements:

1. I understand that this authorization will expire within one year from today's date. Initials: ______________
2. I understand that I may revoke this authorization at any time by notifying Step Forward Therapy Ltd in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions Step Forward Therapy Ltd. took in reliance upon my authorization before it received my revocation. Initials: __________
   You may revoke this authorization by making a written request of Revocation of Authorization. Please address your Request for Revocation of Authorization to: Step Forward Therapy, 3350 W. Salt Creek Ln., Suite 115, Arlington Heights, IL 60005, Attn: Meribeth Cassidy
3. Step Forward Therapy, Ltd. will not condition your treatment or payment for your health care services on your completing and signing this authorization.

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Section B: Must be completed by client or client representative for all authorizations.

Signature of Client or Client's Representative

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Representative Name *(Please Print)*

Date _____________________________ **Relationship to Client** ____