KEY THERAPY
UNLOCK YOUR POTENTIAL

Authorization for Release/Exchange of Information

I give Key Therapy permission to share my health information with:

Type of information:_____Verbal _____Written _____Email (may not be secure/encrypted email account)

List any information that you would not like shared/exchanged at this time: _____

The information that will be shared includes (check all that apply):

My treatment records (plan of cares, progress notes)

My speech language evaluation results

Other: _____

This information is being shared for:

Coordination of care

This authorization will expire:

- 2 years after signed or
- After discharge from therapy.

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be shared.
- I can take back this authorization at any time. Please write to Key Therapy at W175N11163 Stonewood Dr. Suite 106, Germantown, WI 53022 to do this.
- Any information that was used or shared before I took back the authorization cannot be returned.

_____ _____

Print Patient's Name Date

Patient or Parent/Guardian Signature

Relationship to Patient