

Whole Kids Therapy

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**Authorization for Use and Disclosure of
Protected Health Information**

Client Name: _____

Date of birth: _____

This form, when signed, gives authorization for Moira Sullivan, MS, OTR/L, to exchange information regarding the client's occupational therapy treatment.

Name of persons or facilities to whom the information may be disclosed (i.e. school, daycare, camp, etc.):

This authorization is effective indefinitely, unless revoked or terminated by the client's parent(s)/caregiver(s). You may revoke or terminate this authorization by submitting a written revocation to Moira Sullivan.

The information that is disclosed under this authorization may be disclosed again by the person or organization to which it has been sent. The privacy of this information, once sent by our office, may not be protected under federal privacy regulations.

Signature

Date

Printed name

Relationship to patient