5 Stone Therapy | info@5stonetherapy.com | (704) 360-3900

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

Please ***complete form*** and ***email to info@5stonetherapy.com***

I, _____ give permission for 5 Stone Therapy providers to provide necessary evaluation and/or occupational therapy service to the client _____. Date of birth_____.

I authorize the following individual(s)/agencies to receive and distribute necessary medical information via oral, electronic, and/or written means. *Please specify any requested limitations for the release of information to each individual and/or agency (if any):*

_____

_____

_____

_____

_____

I understand that:

- 5 Stone Therapy, LLC, will send evaluation, progress, and/or therapy documentation to the physician's office and Medicaid.
- I have the right to refuse any procedure and/or treatment.
- I have the right to discuss results from the evaluations and treatment with the clinician.
- Any information obtained or released will be used for diagnostic and treatment planning purposes only.
- I must notify the clinician in writing if there are any changes related to the authorization of consent of information with any individuals or agencies.
- This consent is valid for one year, unless the therapist is otherwise notified of any changes provided in writing.

Parent/Caregiver Name (Please Print):_____

Signature:_____**Date:**_____

☐ ***I Accept - Electronic Signature***

Electronic Signature Agreement. By selecting the "I Accept - Electronic Signature" button, you are signing this policy form electronically. You agree and acknowledge your typed or digitally drawn electronic signature is the legal equivalent of your manual/ handwritten signature for the purposes of this policy form.