Patient Name:

_____

ACKNOWLEDGEMENT OR RECEIPT OF PRIVACY POLICIES AND PRACTICES

I, _____, have received a copy of Treehouse Therapies LLC's Notice of Privacy Policies and Practices and authorize use and disclosure of my child's health information, payment, and health operations.

_____

Print Name

_____

Signature Date

_____

Relationship to Patient

I also authorize Treehouse Therapies to disclose my child's health information to my relative/friend:

_____

Relationship to the patient:

_____

CONTACT INFORMATION: PLEASE READ AND INITIAL ALLOWED METHODS OF CONTACT.

_____ I give consent to leave messages on my voicemail

_____ I give consent to receive text messages