



BOSTON
SENSORY
SOLUTIONS, LLC

500 Granite Ave., Suite 1
Milton, MA 02186
information@bostonsensorysolutions.com
617-872-2276
www.BostonSensorySolutions.com

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION FOR

Patient Name

Date of Birth

I, _____, hereby authorize **Bridget Dujardin, MSOTR/L** of Boston Sensory Solutions, LLC and her administrative/ clinical staff to obtain or disclose the following information regarding above named patient. Please check all that apply.

- Confirmation of participation in occupational therapy
- Treatment progress updates/ summary
- OT testing results
- Summary of OT evaluation findings
- On-going consultation
- Professional Collaboration

This information is to be released for purpose of the patient's optimal evaluation, treatment planning, and coordination of services between Boston Sensory Solutions, LLC and

_____.

This authorization shall remain in effect until such time as the patient terminates services with either provider included in this consent or one year from date consent is signed, whichever comes first. Consent may be revoked in writing at any time.

This information should only be released to or obtained from:

Name

Phone

Address

FAX or Email

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. Revocation will not impact professional communications or exchange of information completed prior to date of revocation.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Parent/ Guardian

Date