Therapy Consortium Inc./Wright Therapy Group, LLC.

Phone/Text: 843-289-5211
Fax 843-874-0850
info@WrightTherapyGroup.com

Consent to Release/Obtain Information/Payment/ Treat
& Acknowledgment That You Have Received Our HIPAA Privacy Notice

I have been informed of the use and release of information collected through services received in regards to:

_____ . I request that copies of information in regards to my child be released to/from:
(patient's full name)

1. _____, 2. _____
(Child's Doctor) (Payer/Insurance-Medicaid/MCO and/or private)

3. _____, 4. _____
(Other Doctors) (School-if Appropriate/Daycare)

5. _____, 6. _____
(Babynet- if applicable/EI Group Name) (Other)

(Please read the following and then Initial Below)

____I request that payment of authorized Medicaid and third party payer's benefit be made to Therapy Consortium Inc./ Wright Therapy Group, LLC on my behalf for services furnished to me.

____I authorize Therapy Consortium Inc./Wright Therapy Group, LLC to release any medical information about me that may be needed to determine these benefits payable for related services.

____I understand that I will not be billed for any Medicaid services furnished to me which were billed to Medicaid during the time I had Medicaid coverage for those services.

____I understand that Therapy Consortium Inc./Wright Therapy Group, LLC is required by law to give me a copy of the privacy notice. I understand how my health info1mation may be used and shared.

____I understand that Therapy Consortium Inc./Wright Therapy Group, LLC is required by law to keep my health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history & any treatment notes
- Test Results
- Insurance information

By signing this page you consent to have your child treated by **Therapy Consortium Inc./ Wright Therapy Group, LLC** for Speech Therapy Services and that you have been given a copy of our privacy notice.

_____ _____
Patient's Name Patient's Birthdate

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date