

**United Cerebral Palsy of Tampa Bay, Inc. dba Achieve Tampa Bay
2215 East Henry Avenue Tampa, FL 33610
Phone- 813-239-1179 Fax-813-237-3091**

AUTHORIZATION FOR RELEASE OF/REQUEST FOR INFORMATION

I hereby knowingly and voluntarily authorize United Cerebral Palsy of Tampa Bay, Inc. dba Achieve Tampa Bay to:

_____Receive _____Release or Copy _____Permit Inspection of the following records of:

Name of Participant

Birth Date

To/By: _____

Name of Individual, Agency or Educational Institution

Address

Check applicable records and specify reason for release or authorization to inspect:

<u>RECORDS</u>	<u>REASON</u>
_____ Health/Medical	<u>To provide information for evaluation,</u>
_____ Reports of Lab Tests	<u>treatment, & service delivery purposes</u>
_____ Hearing Screening	_____
_____ Vision Screening	_____
_____ Psychological Evaluation(s)	_____
_____ Psychosocial/Family History	_____
_____ Occupational Therapy Evaluation	_____
_____ Physical Therapy Evaluation	_____
_____ Speech/Language Therapy Evaluation	_____
_____ Other	_____

This authorization shall remain valid for one year from the date signed or until such time as I present a written revocation of this authorization to the agency. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by the privacy regulations.

Signature of Participant or Legal Representative

Witness

Date: _____

Date: _____

Relationship to Participant

Put the name of the consumer's physician on this form. Check receive, release or permit inspection at the top and check the records you want. Be sure to sign and date as the witness.