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

Consent to Use & Disclose Individually Identifiable Health Information for Treatment, Payment and/or Healthcare Operations
Therapy & Family Support Programs

I understand that as part my services, UCP of Tampa Bay, Inc. dba Achieve Tampa Bay ("the agency") receives, originates, maintains, discloses and uses individually identifiable health information including, but not limited to: health records and other health information describing my health history, diagnoses, evaluation/assessment results, treatment plans, progress notes, and billing and health insurance information.

I have been provided with a Privacy Notice that fully explains the uses and disclosures the agency will make with respect to my individually identifiable health information. I understand that the agency cannot use or disclose my individually identifiable health information other than as specified on the Privacy Notice. I have had the opportunity to have any questions regarding the Privacy Notice answered to my satisfaction.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment and healthcare operations, but that if I do not consent, the agency has the right to refuse services.

I have the right to request restrictions on the use or disclosure of my healthcare information. I further understand the agency is not required to agree to a requested restriction. If the agency agrees to a requested restriction, it must honor that restriction unless I tell it to stop in writing or the agency notifies me that it will no longer honor the restriction.

I request the following restrictions on the use or disclosure of my individually identifiable health information.

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- I give permission for the United Cerebral Palsy of Tampa Bay, dba Achieve Tampa Bay therapy and family support programs to evaluate and treat my child. Program staff have explained the services offered & recommended as well as charges & billing arrangements for each service provided.
- This consent shall remain valid as long as my child remains in the program or until such time as I withdraw my consent.
- I authorize the agency to furnish information to insurance carriers or other payers to collect payment for services provided. I hereby assign to the agency named above all payments for services rendered. I understand I am personally responsible for insurance deductibles, co-payments and any charges for supplies or services that are not covered by insurance.
- The agency employs occupational and physical and speech/language therapy assistants. These assistants are under the direct supervision of licensed physical, occupational and speech/language therapists. I give consent to allow therapy assistants to provide services to my child.

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Signature of Participant or Legal Representative

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Relationship to Participant

Date:______________________________

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Signature of Witness

Date:______________________________