Soulshine Pediatric Therapy LLC
Johns Island, SC, Phone: 843-730-1552, Fax: 843-429-6740

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize Soulshine Pediatric Therapy, LLC to use and/or disclose certain protected health information (PHI) to provide treatment, obtain payment for services, evaluate the quality of services provided, perform any administrative operations relevant to the treatment of payment, and when required by law. I have been offered or given a copy of the Notice of Patient Privacy Practices for Soulshine Pediatric Therapy, LLC. I understand that I have a right to request confidential communications and restrictions about how to use and/or disclose my PHI. I understand that I have a right to inspect or amend my PHI, and I have a right to inspect or amend my PHI, and I have a right to file a complaint if I feel my privacy rights have been violated. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: admin@soulshinepediatrictherapy.com.

Patient's Name: _____ Relation to Patient: _____

Signature: _____ Date: _____