Authorization for Disclosure of Protected Health Information

Parent Name: _____
Child's Name: _____
Child's DOB: _____

1. I authorize the following person(s) and/or organization(s) to disclose and receive my protected health information (as specified below):

Name: _____
Organization: _____

Name: _____
Organization: _____

Name: _____
Organization: _____

2. I understand that I may revoke this authorization in writing at any time by sending a signed and dated written statement to Lowcountry Therapy Center, LLC saying that I am revoking my authorization to disclose health records.

3. This authorization expires on (date) _____, or in the event of discharge, whichever occurs first.

I authorize the disclosure of my child's protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I have had the opportunity to read and consider the contents of this authorization.
I confirm that the contents are consistent with my direction.

_____ _____
Signature of Parent/Guardian Date