Authorization for Use and Disclosure of Health Information

Section A:
I hereby authorize the use and disclosure of my and my child's protected health information, which is deemed necessary in connection with my child's treatment, as described in the Notice of Privacy Practices.

_____ _____
Patient Name (please print) Date

_____ _____
Parent or Legal Guardian Name (please print) Parent or Legal Guardian Signature

Section B:
I hereby authorize the following person(s) to receive my child's protected health information.

Please list any person(s) that you consent to have your child's information disclosed to, either verbally or in writing. This information can be changed at anytime by giving us written notice of your requested changes.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____
Name (please print) Relationship to Child (please print)

_____ _____
Patient Name (please print) Date

_____ _____
Parent or Legal Guardian (please print) Parent or Legal Guardian Signature

For Office Use Only

We attempted to obtain written consent for use and disclosure of health information according to the Notice of Privacy Practices, but consent could not be obtained because:

- ☐ Parent or Legal Guardian refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

_____

_____ _____ _____
Office Personnel (please print) Office Personnel Signature Date