AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION ABOUT A MINOR

Your family's privacy is very important. However, there may be a time when we need to speak with another person, professional, or agency to coordinate care and provide the best possible service to your child.

Child's Name: _____ Date of Birth: _____

I authorize my child's clinician, _____ and his/her administrative staff to release and/or receive the following information: (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible)

_____

_____

This information should be released only to the following person(s) or agencies:

_____

_____

I understand that:

- Unless otherwise specified, this authorization shall remain in effect for up to 90 days after the date of signing.
- I have the right to revoke this authorization at any time by sending such written notice to my clinician. However, my request will not apply to actions my clinician has already taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.
- My clinician generally may not condition services upon my signing this authorization unless the services are provided to me for the purposes of creating health information for a third party.
- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule. My clinician cannot guarantee that the recipient will protect my child's information once it leaves his office.

Signed: _____ Date: _____
Client (if age 13 or over)

Signed: _____ Date: _____
Parent or legal guardian