AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Child's Full Name____ DOB____________________________________

I *(Print Name - Parent/Legal Guardian)* ____________________________________, authorize Jacob's Promise LLC the use or disclosure of the above named individual's health information as described below.

Parent/Legal Guardian, please initial below to indicate records to be released to or exchanged with **Jacob's Promise LLC**. *Please* ***INITIAL (DO NOT CHECK)*** *the appropriate space below.* **(Choose one option: A B or C)**

A. _______ All records including, but not limited to, the following:
Medical, Psychiatric/Psychological, Speech-Language, Educational, Occupational Therapy, Physical Therapy, All Other Records

B. _______ All records except (***List exceptions, please print*****):**

____

____

C. _______ I do not give my permission for Jacob's Promise LLC to release or exchange information with any other agency.

D. Method of Disclosure
Parent/Legal Guardian, please initial below to indicate the format to which you approve of your child's records to be released to or exchanged with **Jacob's Promise LLC** *Please* ***INITIAL (DO NOT CHECK)*** *the appropriate space below.*

_______ Electronic (We use a secure email/fax and recommend checking if the recipient uses a secure email/fax)
_______ Hard Copy (Charges will apply)
_______ Mail (Charges will apply)
_______ Flash Drive/CD (Parent must provide)

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand authorizing the use or disclosure of the information identified above is voluntary.

AUTHORIZATION:

____
Parent/Legal Guardian - Print Name

____ ______________________________
Parent/Legal Guardian - Signature Date

By entering your name above, you agree that it represents your signature and you acknowledge that this is a legally binding document.

REV 08/20/2015