

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____

Date of Birth: _____ Social Security Number: _____

1. I (We) hereby give my (our) consent to _____
to release my child _____'s protected health information¹ as described herein to
_____, for the purpose of legal investigation and/or legal advocacy. I
understand that this authorization is voluntary and made at my request. I understand that, while
_____ is/are not subject to federal and state health information privacy
laws², subsequent disclosure by these organizations may not be protected by those laws.

2. The following is a specific description of the protected health information that I authorize for disclosure
(authorization to disclose psychotherapy notes must be separate): _____

3. I understand that I may revoke this authorization at any time, except to the extent that the organizations named above
have taken action in reliance on this authorization.
4. This Authorization for Release of Information will remain valid for a period of one year from the latest date below.
5. A photocopy and/or faxed copy of this Authorization for Release of Information is as effective as the original.

Client's Signature (child—if applicable)

Date

Parent's Signature

Date

Parent's Signature

Date

¹ Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508.

² These laws apply to health plans, health care providers, and health care clearinghouses.