Release Protected Health Information

Child's Name:________________ DOB:____________________

I authorize Kid Sense Therapy to share specified Protected Health Information (PHI) including but not limited to: evaluation reports, treatment plans, progress notes and therapy documentation, as well as verbal communication pertaining to my child.

FROM:
Kid Sense Therapy
Dr. Calvin Jones Hwy, Suite 200
Wake Forest, NC 27587
(P) 919-673-4246
(F) 919-263-9605

TO:

Name:_____________________ Agency______________________

Name:_____________________ Agency______________________

Name:_____________________ Agency______________________

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. Authorization is good for length of time that client is under care of Kid Sense Therapy. I understand that I may revoke this authorization at any time, verbally or in writing.

Signature of Parent/Guardian Date

Patient Notification of Privacy Policies (HIPAA Authorization)

I hereby authorize use or disclosure of protected health information about my child as described below:

1. Confidential information is stored in a secure location away from public access. All computers and PDA's are only accessed by password.
2. Kid Sense Therapy, PLLC is authorized to disclose health information to insurance companies or referring physicians for the purpose of requesting doctor's orders, authorization of services, or to obtain reimbursement for services. Information may be sent via mail or fax with procedures in place to limit the likelihood of unauthorized access.
3. Kid Sense Therapy, PLLC and its employees are authorized to use or disclose pertinent health information that is required for therapy purposes.
4. Kid Sense Therapy, PLLC may disclose protected health information considered pertinent to care to specified professionals (ie social workers, teachers, physicians, therapists, etc.) with a signed release form from parent or guardian.
5. I, the parent/guardian, understand that all employees of Kid Sense Therapy, PLLC are given a copy of Privacy Policy Procedures, sign a confidentiality agreement, and will only access information required to complete their job responsibilities.
6. I, the parent/guardian, may revoke this authorization by notifying Kid Sense Therapy, PLLC in writing of my desire to revoke it. However, I understand that any action already completed prior to the request to revoke this authorization cannot be reversed, and my revocation will not affect those actions.
7. This authorization expires when the client is discharged from therapy, although the company will always use professional discretion when sharing any PHI.

__________________________ ________________________

Parent/Guardian signature Date

____________________________ ____________________________

Parent/Guardian printed name Child's Name (printed)