Part 3: HIPAA Authorization

This authorization will expire one year from the date signed unless an earlier date is provided here:_____

Child Name: _____DOB: _____

I hereby authorize Thera-Play Pediatrics to release or obtain my individually identifiable information,

Including; contact information, pictures of my child, information about physical health and/or mental

health, physical or mental condition, healthcare or other services, and payment for services.

I understand that:

- I am entitled to a copy of this form.
- A copy of this permission form is as valid as the original.
- I may revoke this authorization at any time by notifying Thera-Play Pediatrics in writing. This will not affect any action Thera-Play Pediatrics took in reliance on this authorization before it was revoked.
- If I refuse to authorize disclosure of my child's unrelated healthcare information, then Thera-Play Pediatrics will not deny services.
- Once information is released to a third party according to this authorization, Thera-Play Pediatrics cannot prevent its re-disclosure.
- This authorization does not limit the ability of Thera-Play Pediatrics to use or disclose my child's health information as otherwise permitted by the state and federal law.
- Disclosed information may be oral or written.

Print Parent/Legal Guardian's Name: _____

Describe Relationship to Patient: _____

Parent/Legal Guardian's Signature: _____ Date: _____

RELEASE:

Disclosure to: _____

Disclosure from: _____

Date: _____

Type of information:

_____

_____