AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Authorization for Disclosure of Information: I voluntarily consent to and authorize Johannah Hornak (Provider) to use or disclose my child's health information *(excluding session notes)* during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my child's health information to be released to the following recipient(s)

Name: _____

Address: _____

Name: _____

Address: _____

Purpose: I authorize the release of my child's health information for the following specific purpose: _____ .
(Note: "at the request of the parent/guardian" is sufficient if the client is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information:
(check the applicable box below)

☐ All of my child's health information that the Provider has in her position, including information relating to any medical history, mental or physical treatment received.
☐ Only the following health information:
_____ .

Term: I understand that this Authorization will remain in effect:
(check the applicable box below)

☐ From the date of this Authorization until _____, 20_____ .
☐ Until the Provider fulfills this request.
☐ Until the following event occurs: _____.

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name