AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO SCHOOL

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

[ ] I do not want any information released to my child's school, school district, or teachers

I understand that if I do not sign the release, test reports or information needed to facilitate my child obtaining modifications to their educational programming will not be shared. I understand my child may not receive the services they need to optimize their success in the classroom.

[ ] I authorize Northshore Counseling & Wellness, LLC to release my child's protected health information to my child's school/district/teachers if needed to facilitate getting services for my child.

School: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

A copy of this authorization shall be as valid as the original.

I understand I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the latter provides greater access rights)
- Refuse to sign this authorization
- Receive a signed copy of this authorization

_____ _____

Signature of Parent/Guardian and Date Witness and Date