ADVANCE KIDS IN MOTION OT, PLLC

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (updated 1/1/2020)

Please fill out this form completely. You must initial where necessary.

1. _____ (Initial) I, _____ (parent/legal guardian name), understand that **Advance Kids In Motion OT, PLLC** will not share any of my family's personal information with anyone or any agency without my written consent unless legally required to do so.

This includes;

a. Verbal Conversations
b. Phone conversations
c. Emails
d. Written reports- evaluations, bills, progress reports

2. _____ (Initial) **Advance Kids In Motion OT, PLLC** has my permission to audiotape during the session, if necessary, for the direct purpose of my child's therapy. All audio will be erased as soon as it is transcribed.
3. _____ (Initial) all bills will be emailed using a password-protected program.

Authorization

I authorize Advance Kids In Motion OT, PLLC to use and disclose the protected health information to

_____ (Individual receiving information)

i.e., Pediatrician, teachers, therapists, grandparents, babysitter/nanny, etc.

Effective Period

This authorization for release of information covers the period of healthcare from:

_____ to _____.

I understand that I have the right to revoke this authorization, **in writing**, at any time.

Please note, this HIPAA form includes information about invoices. If you have requested that the billing be sent to a person other than the parent or legal guardian, you MUST put their name in the Authorization portion of this form.

_____ _____

Parent/Legal Guardian Signature Date

_____

Parent/Legal Guardian Name (Print)