

## Voluntary disclosure of protected information

I hereby authorize the use or disclosure of my child's Protected Health Information and other information as described below. I understand that this authorization is voluntary.

Parent: \_\_\_\_\_ Child: \_\_\_\_\_

Child Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_\_ Address: \_\_\_\_\_

### Persons/ Entities authorized to receive, use, and disclose the information:

- Any healthcare individuals.
- The following individuals or groups: \_\_\_\_\_

### Persons/ Entities authorized to receive, use, and disclose the information:

Clinical staff of Creative Health Solutions as needed, supervisor Judy Feingold, OTR/L.

### Description of information:

Discussion with the child's healthcare provider concerning the child's condition and documents, records, test results, etc., the provider believes would help in the child's treatments. Please provide thematic limits, if any. (Indicate and use additional space on the back if necessary.)

### Purpose of Authorization:

This Authorization for use or disclosure of information is at the request of the parent and the relevant staff of Creative Health Solutions to help in the therapeutic treatment of the child.

### I acknowledge and understand that I:

1. am voluntarily providing this authority to help in the treatment of my child;
2. may see and copy any information described in this form;
3. may copy this Authorization after I sign it, and if I am unable to make a copy, I may request a copy from Creative Health Solutions LLC;
4. may revoke this Authorization at any time by verbal or written notice (including email and web hosting messages) to Creative Health Solutions LLC, but that any revocation shall have no effect on actions which have been taken by Creative Health Solutions LLC prior to receiving my revocation;
5. have the right to refuse to sign this authorization.

I have read and understand the contents of this Authorization.

\_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Signature of Parent