HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

I/We hereby **give permission and consent** to **Intentional Interventions, LLC** to **release and exchange** confidential information in my child's clinical record to the following organization:

Company Name ____
Company Address ____
Company Address ____
Phone: ____
Fax: ____

Reason for Release

- ☐ Personal
- ☐ Treatment/Care Coordination
- ☐ Other

This authorization for release of information covers:(select one)

- ☐ Entire clinical record to cover full length of treatment
- ☐ Limited Information and Specified Date Rages

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

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand this Disclosure will expire December 31, 20________

Client's Name:___________________________________ Date of Birth: ___ / _____ / _____

Parent/Guardian #1: ________________________________
(Print Name)

Parent/Guardian #1: ________________________________ Date: _____ / _____ / _____
(Signature)

Phone: 609-380-1122 Fax: 609-374-9166
707 Whitehorse Pike C3
Absecon, NJ 08201
www.intentionalinterventions.com
email:info@intentionalinterventions.com

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