

KINDER
KONSULTING



CLIENT NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

AUTHORIZATION TO EXCHANGE HEALTH INFORMATION - SCHOOL CONSENT

The purpose of this HIPAA consent is to release or obtain electronic protected health information concerning the above-named client. Health information may relate to my past, present or future physical or mental health condition, the provision of my health care, or payment for my health care services.



1. **The person whose information may be used, disclosed, or exchanged is:**

   Name: _____

   DOB: _____

2. **The information may be disclosed to/exchanged with:**

   Entity/School Name: _____

   Address: _____ Fax: _____

   City/State/Zip: _____ Phone: _____

3. **Location of Services:**
   - ☐ I GIVE Consent for my child to receive services in the school/daycare that he/she is attending.
   - ☐ I DENY Consent for my child to be seen in the school/daycare. This consent is for Exchange of Information ONLY, and not for services to be conducted at this location.

4. **The information that may be disclosed/exchanged includes all records of diagnosis and treatment. Disclosures of psychotherapy notes is not permitted.**
   Additional disclosure limitations:

   _____

   _____

5. **This information is permitted to be disclosed/exchanged for treatment purposes only.**
   Additional details surrounding the purpose of information disclosure/exchange:

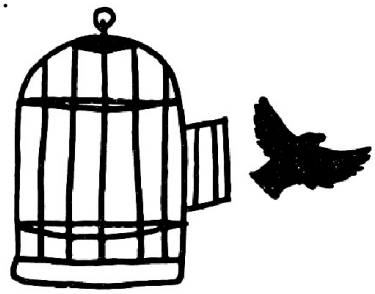
   _____

   _____

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6. **The persons or organizations receiving any disclosure of this information will be permitted to re-disclose any information received based upon the consent to organizations or individuals providing treatment to the client.** I understand that Kinder Konsulting & Parents Too, Inc. cannot guarantee that the Recipient will not re-disclose my health information to a third party that may not be subject to federal laws governing privacy of health information.



7. **Consent:**
   - ☐ I GIVE CONSENT for protected health information exchange
   - ☐ I DENY CONSENT for protected health information exchange

   Effective: _____

   Expires: _____ or upon discharge

8. **I understand that this permission may be revoked.** I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at Kinder Konsulting & Parents Too.

9. **I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Kinder Konsulting & Parents Too, Inc.**

I am the person or parent/legal guardian of the person whose records will be used, disclosed, or exchanged. I give permission to use, disclose, and exchange records as described in this document.

Signature of Client and Parent/Guardian: _____
Name of Parent/Legal Guardian: _____ **Date:** _____
Parent/Guardian Email: _____ **Cell:** _____

Signature of Clinician: _____
Name of Clinician: _____ **Date:** _____
Clinician Cell: _____