THE CARRUTH CENTER
AT THE PARISH SCHOOL

Authorization to Request or Disclose Protected Health Information

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to release or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

This form contains four (4) sections that authorize The Carruth Center to request or disclose protected health information. **Please complete sections that apply to you. Please mark N/A through sections that do not apply to you.** Both parents must complete this form unless a divorce decree is produced to show otherwise.

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Email (*Optional*): _____

I. Permission to Release or Obtain Protected Health Information

I hereby authorize The Carruth Center to request protected health information from and/or disclose protected health information to the following entities **(initial all that apply):**

The Parish School: _____ initials _____ initials	Spectrum of Hope: _____ initials _____ initials
Dr. Randi Raizner: _____ initials _____ initials	Holy Spirit Episcopal School: _____initials _____ initials
Other Name: _____ Phone Number: _____ Address: _____ _____ initials _____ initials	
Other Name: _____ Phone Number: _____ Address: _____ _____ initials _____ initials	
Other Name: _____ Phone Number: _____ Address: _____ _____ initials _____ initials	

The information to be disclosed or requested (initial any that apply):

_____ ST, OT, PT or Music Therapy client therapeutic/progress notes
_____ Diagnoses
_____ ST, OT, PT or Music Therapy assessment or evaluation results
_____ Mental Health records (except psychotherapy notes)
_____ **Entire record**

Reason for request or disclosure of protected health information (choose all that apply):

☐ Treatment/coordination of care ☐ Legal purposes ☐ Employment
☐ Personal use ☐ School ☐ Other (specify): _____

II. Insurance
I hereby authorize The Carruth Center to disclose protected health information to my child's insurance company for the purpose of claims processing when a request is made by his/her parent or guardian, or when a request is made from the insurance company directly.

Insurance Company: _____

The information to be disclosed or requested (initial any that apply):
_____ ST, OT, PT or Music Therapy client therapeutic/progress notes
_____ Diagnoses
_____ ST, OT, PT or Music Therapy assessment or evaluation results
_____ Mental Health records (except psychotherapy notes)
_____ **Entire record**

III. Caregivers and/or Family Members
I hereby authorize The Carruth Center to disclose protected health information regarding my child to the following caregivers or family members:

Name	Address	Phone	Fax/Email

The information to be disclosed or requested (initial any that apply):
_____ ST, OT, PT or Music Therapy client therapeutic/progress notes
_____ Diagnoses
_____ ST, OT, PT or Music Therapy assessment or evaluation results
_____ Mental Health records (except psychotherapy notes)
_____ **Entire record**

Reason for request or disclosure of protected health information (choose all that apply):
☐ Treatment/coordination of care ☐ Legal purposes ☐ Employment
☐ Personal use ☐ School ☐ Other (specify): _____

IV. Pick Up Release
The following people have permission to pick up my child from therapy. If I have included their information in Part 3 of this form, my child's therapists may share information about therapeutic progress or session results at the end of my child's therapy session(s). Please note, if a person not on this list brings your child to therapy, your child will be released to that same person upon the completion of their therapy session.

Person 1

Full Name: _____ State ID#: _____

State of issuance: _____ Phone Number: _____

Person 2

Full Name: _____ State ID#: _____

State of issuance: _____ Phone Number: _____

The individual(s) signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect from the date of your signature below until authorization is revoked, in writing, by you. Any changes to the information on this form should be reported to The Carruth Center office in writing.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization in full or in part at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and by initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Parent/Legal Representative: _____ Date: _____

Printed Name of Parent/Legal Representative: _____

If Legal Representative, relationship to Patient: _____

Parent/Legal Representative: _____ Date: _____

Printed Name of Parent/Legal Representative: _____

If Legal Representative, relationship to Patient: _____