# Coordination of Care -- HIPAA Permission to Release Information

In an effort to provide the highest level of care, it is important that Impact clinicians be in contact with client's primary care physician and/or other healthcare and behavioral health providers. In order to comply with various HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our clients and/or their parents/guardians sign this permission to release information form.

I _____ parent/legal guardian of _____
give permission to Impact and its representatives to discuss and/or release information regarding the therapeutic treatment of _____ , DOB_____
with the following persons, professionals, institutions/agencies:

**Provider Name**:_____ **Provider Title**:_____

Tel: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

State: _____ Zip Code: _____

**Provider Name**:_____ **Provider Title**:_____

Tel: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

State: _____ Zip Code: _____

**Provider Name**:_____ **Provider Title**:_____

Tel: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

State: _____ Zip Code: _____

**Provider Name**:_____ **Provider Title**:_____

Tel: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

State: _____ Zip Code: _____

**Provider Name**:_____ **Provider Title**:_____

Tel: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

State: _____ Zip Code: _____

_____ _____

Name of Parent/Legal guardian Signature

_____

Date

Confidentiality statement for the Health Insurance Portability and Accountability Act (HIPAA), and their respective regulations protect the confidentiality of medical, educational, and personal information of clients. Such information may not be disclosed except as authorized by law or as authorized by client's parent or legal guardian. These privacy laws and regulations apply to all persons, including all persons conducting observations in clinical settings. All observers are required to agree to and sign this confidentiality statement. I understand that as an observer, I may see, hear, or be exposed to confidential information about clients. This information includes but is not limited to: medical information, information about a client's disability, performance, or other services received, and any other related information about a client. I acknowledge that it is my responsibility to respect the privacy and confidentiality of this information.

I will not access, use, or disclose any confidential information outside of my observation of client: _____. I understand that if I breach any provision of this Agreement, I may be subject to civil or criminal liability.

_____ Observer's Name (Please Print)

_____ Observer's Signature

_____ Date

**SEE NEXT PAGE TO DECLINE**

**Complete this side only if you are refusing to grant Impact permission to share information with your child's other healthcare providers.**

# Coordination of Care -- HIPAA Decline Permission to Release Information

I _____ parent/legal guardian of _____

**REFUSE TO GRANT** permission to Impact and its representatives to discuss and/or release information regarding the therapeutic treatment of _____ , DOB_____ with other persons, professionals, institutions/agencies.

_____ _____

Name of Parent/Legal guardian Signature

_____

Date