Authorization to Release Protected Health Information (PHI)

I_____, parent and/or legal

guardian of _____, DOB_____,

authorize Stacey Kohn to disclose to and/or obtain from

_____

The following information regarding my child: _____

_____

- The purpose of obtaining this information is to improve assessment and services, share information relevant to services and when appropriate, coordinate treatment.
- This consent is effective for one year from the date below.
- I understand that I have the right to revoke this authorization in writing at any time.
- I understand that I do not have to sign this authorization to release information in order to receive Triangle Parent Navigator services.
- My right to confidentiality has been explained to me and I understand what information will be released or obtained, the need for the information, and that state statutes and regulations protect the confidentiality of authorized information.
- I understand that any information Ms. Kohn receives pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by federal medical privacy laws.
- This authorization is fully understood and made voluntarily on my part.

_____

Signature of Parent Date

_____

Stacey Kohn, Parent Navigator Date