Holsman Children's Therapy Center, LLC
15-01 Broadway Suite 14B&C
Fair Lawn, NJ 07410
Phone: (201) 351-1682
Fax: (732) 428-5513

CONSENT TO SHARE / RELEASE HEALTH INFORMATION

Holsman Children's Therapy Center, LLC is an agency which provides therapy services to children. Holsman Children's Therapy Center, LLC must have your consent to discuss any confidential information with any of your child's other care givers that are not a parent or legal representative. Additionally, we need authorization to request information from any professional outside Holsman Children's Therapy Center, LLC.

Your consent is being requested to obtain, share and discuss information about your child with your child's care givers and providers in order to plan and provide effective and appropriate services while your child is in their care. Coordination of care is required by all health plans.

You may choose not to give consent, to give consent to share information for some items but not others, or to give consent to share information on all items. If you choose to give consent, you may retract some or all authorization(s) at any time, with written notification to our office.

Child's name: _____ Child's Date of Birth: _____

I give my informed consent to Holsman Children's Therapy Center LLC practitioners to release information to:

1) _____ 2) _____

I give my informed consent to Holsman Children's Therapy Center LLC practitioners to request and receive information from:

1) _____ 2) _____

Information that may be released: Written _____Verbal _____Both _____

Please check all areas yes or no:

Evaluation/Assessment Reports:	_____Yes _____ No
Session Clinical Notes:	_____Yes _____ No
Medical Reports:	_____Yes _____ No
Discussion of Strategies/Ongoing Activities:	_____Yes _____ No
Discussion of Diagnosis/Medical Condition:	_____Yes _____ No
Discussion of Transition Plans:	_____Yes _____ No
Coordination of care:	_____Yes _____ No

I give my informed consent to have the above-named caregiver(s) sign the Therapy Session Verification Log and/or clinical notes in my place and observation of service session. _____Yes _____ No

This record will be part of the child's file. This record is subject to the Health Insurance Portability and Accountability Act (HIPAA). This record is available for my review and may be reproduced and corrected at my request. I understand that I may change or withdraw this release of information/consent at any time.

This authorization shall expire on: _____
Date

Printed name of parent/legal representative: _____

Signature of parent/legal representative: _____