

**The Brent Woodall Foundation for Exceptional Children**  
**AUTHORIZATION FOR RELEASE OF THERAPEUTIC INFORMATION (HIPAA)**

Child's Name: _____		
DOB: _____	Phone: _____	
Address: _____		
City: _____	State: _____	Zip: _____

I hereby authorize the Brent Woodall Foundation for Exceptional Children to release and discuss my child's confidential information with the following people, companies, organizations:

- Insurance Company
- Grant Organizations or 3<sup>rd</sup> Party Funding Sources
- Child's School (name of school) \_\_\_\_\_
- Other Therapy Providers (please list name, company, and phone number)  
\_\_\_\_\_  
\_\_\_\_\_
- Family or Friends other than the Child's legal guardians (please list name, phone number, and relationship to the child)  
\_\_\_\_\_  
\_\_\_\_\_
- I do not give my permission to release information to anyone other than the insurance company or 3<sup>rd</sup> party funding source.

This authorization will remain in effect from the date of my signature below until revoked upon written notification.

**RIGHT TO REVOKE:**

I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization and understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

\_\_\_\_\_  
**Signature of Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to Child**