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 3rd 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 3rd party funding source.

This authorization will remain in effect from the date of my signature below until revoked upon written notification. I, _____ (parent 1) and _____ (parent 2) have read, understand, and agree to the policies of the Brent Woodall Foundation for Exceptional Children.

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 **Form effective through December 31, 2021**