732.994.PUZZ (7899) | 3425 US 9 N., Freehold, NJ 07728 | info@ThePuzzlePlace.org | www.ThePuzzlePlace.org

HIPAA AUTHORIZATION FOR USE / DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize **The Puzzle Place, LLC** the use and disclosure of my health information as described below.

Childs Name:_____ **Date of Birth:**_____/_____/_____

Person(s) or Organization(s) authorized to receive the information:

_____

_____

Specific description of the information that may be used or disclosed (including date(s) if applicable):

_____

_____

Specific description of how the information will be used:

_____

_____

1) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying The Puzzle Place, LLC in writing.
2) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
3) I may inspect or copy any information used or disclosed under this agreement.
4) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Signature of Parent/Guardian 1 **Date**

_____ _____

Signature of Parent/Guardian 2 **Date**

NOTES

- You have the right to know specifically what information you are authorizing for release
- You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s))*
- You have the right to know who is going to use the information and what it is going to be used for *(e.g. John Smith, PhD / Research)*
- You have the right to receive a copy of this form.
- This form does not constitute legal advice.