**AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION**

Section A: Client complete for all authorizations. Please check and initial statement(s) that applies.

**[ ]** I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations. **Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ]** I hereby authorize The Whole Child Associates to obtain individually identifiable health information as described below. I understand that this authorization is voluntary. Information obtained will be for the sole use of The Whole Child Associates to provide treatment, receive payment or for health care operation purposes. **Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The Whole Child Associates may release to or obtain form as indicated below (physicians, healthcare providers, educational programs, or other agencies) my health information.

Balanced Bodies Therapists Oak Brook, IL

**Name, Address, Phone, Fax**

**Name, Address, Phone, Fax**

**Name, Address, Phone, Fax**

Description of information to be disclosed or obtained:

[ ] Evaluation/Assessment [ ] Progress Note/Summary [ ] Medical History

[ ] Discharge Reports [ ] Psychological Reports [ ] IEP/School Records

[ ] Medical Consultation [ ] Physical/Immunization Records

[ ] Other as here specified \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT or the CLIENT’s REPRESENTATIVE READ AND INITIAL THE STATEMENTS:**

1. I understand that this authorization will expire within one year from today’s date. **INTIALS:\_\_\_\_\_\_\_\_**
2. I understand that I may revoke this authorization at any time by notifying The Whole Child Associates in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions The Whole Child Associates took in reliance upon my authorization before it received my revocation.

**INTIALS:\_\_\_\_\_\_\_**

You may revoke this authorization by making a written request of Revocation of Authorization. Please address your Request for Revocation of Authorization to: The Whole Child Associates, 281 N. Willow Road, Elmhurst, IL 60126, Attn. Privacy & Security Officer.

1. The Whole Child Associates will not condition your treatment or payment for the health care services on your completing and signing this authorization.

The Whole Child Associates personnel to complete for requests to obtain information:

1. The purpose of the use or disclosure is : [ ] Program Planning [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. The Whole Child Associates \_\_will **X will\_NOT** receive direct or indirect compensation in exchange for using or disclosing the information listed above.

**MUST BE COMPLETED BY CLIENT OR CLIENT REPRESENTATIVE FOR ALL AUTHORIZATIONS.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Client or Client Representative Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s Representative Name (Please Print) Relationship to Client**

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**