Consent To Release Protected Health Information

Patient Name:

DOB:

Parent Name:

Phone:

Address: _____

_____

_____

I authorize:

As You Are
99 E Main St, Ste 200
Franklin, TN 37064-4186
Phone: 866-219-8595

To release my child's protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to: (New Doctor, Lawyer, Parent, School, Daycare, Therapy Center, etc.

Name: _____

Address: _____

Email: _____

Telephone: _____

Fax: _____

The purpose of this request is:

Further Medical Care _____ Personal _____ Other: _____

I authorize the release of the following protected health information:

Entire Record _____ Other: _____

I understand that this authorization will expire one (1) year from the date on which it was signed. I understand I may revoke this consent at any time by contacting support@asyouare.com; however, that will not affect disclosures made in reliance on this Authorization. I understand that my child may receive care even if I do not consent to release their health records.

Parent/Guardian Signature:

Parent/Guardian Printed Name:

Date: