9360 Falls of Neuse Rd, Suite 105 Tel:984-301-6494

Raleigh, NC 27615-2485 www.knowandshowsolutions.com

KNOW AND SHOW SOLUTIONS, PLLC

Release of Information

Person filling out form: _____

Client's Name: _____

Relation to Client: _____

Client Date of Birth: _____

Client Address: _____

Client Phone: _____

I authorize Know and Show Solutions, PLLC to release my child's protected health information (PHI) for the following purposes:

☐ Continuity of Care
☐ Insurance/Payment
☐ Legal Purposes
☐ Other: _____

The following information may be disclosed (check all that apply)

☐ Evaluation reports
☐ Treatment Plans
☐ Therapy Progress Notes
☐ Attendance Records
☐ Other: _____

Release information to (please list name/organization, address, phone/fax):

_____

_____

_____

Method of release

☐ Mail
☐ Fax
☐ Email (unencrypted)
☐ Other: _____

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This authorization will expire on the below date or event. If no date/event is specified, the authorization will expire 12 months from the date of the signature.

I understand that I may revoke this authorization at any time by providing a written notice to Know and Show Solutions, PLLC, except where information has already been released in reliance on this authorization.

I understand that:

- My child's treatment or payment is not contingent upon signing this form.
- Information disclosed may be re-disclosed by the recipient and may no longer be protected under HIPAA.

By signing below, you confirm that you are the Parent/Legal Guardian of the Minor Client listed above, and that you have read and understand this Release of Information. You agree to the permissions outlined above regarding the release and sharing of information in support of your child's care.

Print Name: _____

Signature: _____

Date: _____