PEREZ & ASSOCIATES, LLC
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CUSTODIAL PARENT/ GUARDIAN AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION OF A MINOR CHILD

Child's name: _____ Date of birth: _____

When you complete and sign this form, it authorizes Perez & Associates, LLC (PALLC) to release protected information from your child's clinical records to the person or agency below, or to obtain information from this person or agency. You have the right to revoke this authorization, in writing, at any time by sending notification of this revocation to the PALLC mailing address.

I, _____ , give permission to PALLC to disclose or obtain the following information in regard to the above-named minor's psychological/medical /psychoeducational treatment or evaluation. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. The particular information to be disclosed/obtained is the following (please be specific):

_____

_____

This authorization will remain in effect until: _____

The following person or agency is authorized by this form to receive and disclose the protected health information selected above:

Name _____

Address_____

Phone _____ Fax _____

I fully understand and accept the terms of this authorization.

_____ _____
Signature of Parent/ Legal Guardian Date

_____ _____
Printed name of Parent/ Legal Guardian Relationship to the child