Scottish Rite Childhood Language Center
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____________________, parent of ____________________, authorize the Scottish Rite Childhood Language Center to:

_____ Use my child's protected health information for billing and reporting purposes.

_____ Disclose my child's protected health information to the following individuals or agencies (list applicable insurance carriers, physicians, educational institutions)

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This information may be sent or shared via:
(check all that apply)

_____ U.S. Mail
_____ Fax
_____ Email
_____ Telephone

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Scottish Rite Childhood Language Center's Privacy Contact: Executive Director, 4202 Hermitage Rd, Richmond, VA 23227

The Scottish Rite Childhood Language Center will not condition my child's treatment or enrollment in the program on whether I provide authorization for the requested use or disclosure.

______________________________ ______________
Signature of Parent or Guardian Date

______________________________ ______________
Witnessed by Date