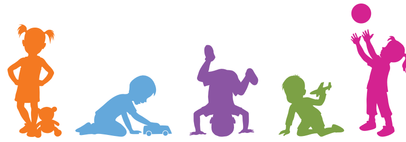

kids therapy made simple

# Acknowledgment of Receipt of Notice of Privacy Practices & Authorization and Release Form

You may refuse to sign this acknowledgment & authorization. In refusing, *we may not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective HIPAA Notice of Privacy Practices for Kids Therapy Made Simple. A copy of this signed & dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION (PHI) RELEASE SHOULD I REQUEST TREATMENT BE SENT TO OTHER THERAPISTS/FACILITIES IN THE FUTURE.

______________________________ ______________________________ ______________________________
Print Name of Parent/Guardian Name of Patient Patient Date of Birth

______________________________ ______________________________
Signature Date

Comments regarding Acknowledgments of Consents: ______________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR CHILD'S HEALTH INFORMATION:
(e.g. step-parents, grandparents, relatives and any caregivers who may receive access through written or verbal communication to your child's records)

Name: ______________________________ Relationship to Child: ______________________________

Name: ______________________________ Relationship to Child: ______________________________

Other Therapists: ______________________________

School Name: ______________________________

Physician: ______________________________

Please list any other(s): ______________________________

Please list any custody, divorce or family matters we should be aware of: ______________________________

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I authorize contact from this office to **confirm** my appointments, treatment & billing information via:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Email Confirmation ☐ All Methods Acceptable

I authorize information about my child's treatment be conveyed via:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Email Confirmation ☐ All Methods Acceptable

*Kids Therapy Made Simple, under the current HIPAA Omnibus Rule, provides you this information with your knowledge and consent. By signing the below, you acknowledge understanding and acceptance of the Kids Therapy Made Simple HIPAA Private Practice Notice.*

______________________________ ______________________________ ______________________________
Print Name of Parent/Guardian Signature of Parent/Guardian Date

helping kids with life

**Kids Therapy Made Simple**
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