DCCH Center for Children and Families
Therapy Referral
Please print all information.
Fax completed form to 859-331-1614

Student's Name: _____ Date: _____

Parent/Guardian's Name: _____ Referred by: _____

Contact #: _____ Type of Insurance: _____

Reason for referral: _____

AUTHORIZATION TO USE OR DISCLOSE PHI

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-19, established regulations to govern the privacy of *individually identifiable health information* obtained, created or maintained by certain entities. HIPAA mandates that Health Care Providers procure an authorization to release *Protected Health Information* (PHI). As a health care provider, DCCH is required to adhere to privacy standards defined in the Privacy Rule.

I authorize DCCH to use and/or disclose my *Protected Health Information* (PHI) as follows:

Purpose:

To aid in treatment

Individuals Authorized to Release Information:	TO	**Individuals or entity authorized to receive my *Protected Health Information:***
Turkey Foot Middle School	And	The Therapy Center at DCCH
The Therapy Center at DCCH		Turkey Foot Middle School

Expected Duration of Services (if applicable to this Authorization):

Services/Event Start Date: _____ Services/Event Expected End Date: _____ ☐ Event/Services to extend beyond two years

Authorization Period:

For the expected duration of services indicated above, or two years from the date this form was signed below if the expected duration of services extends beyond 2 years, or if I exit DCCH programs/services or if this authorization is revoked by me in writing

Protected Health Information which may be released:

Information to facilitate services.

- I understand I may inspect or request copies of any information disclosed by this authorization.
- I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to John Ross, DCCH's Privacy Officer at 75 Orphanage Road, Ft. Mitchell, KY, 41017. I understand a revocation is not effective to the extent that DCCH has already relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand I may refuse to sign this authorization and that DCCH will not condition any aspect of my treatment on whether I provide authorization for the requested use or disclosure.

Student's Printed Name _____ Parent/Guardian's Signature _____ Date _____

DOB: _____ Witness Signature: _____ Date: _____