CASA Health & Wellness

Authorization to Exchange Protected Health Information

By signing this document, I, *(name)*_____,
parent/guardian of *(child's name)*_____,
hereby authorize Lily Cardasis, CASA Mental Health & Wellness Counselor, to exchange confidential information and records with
_____, for the purpose of:

☐ Coordination of treatment

☐ Other:

I understand the following:

- *Signing this form is not a requirement of treatment.*
- I have the right to receive a copy of this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.
- I have the right to revoke this authorization at any time. Request must be made in writing and sent to lily@lilycardasis.com, delivered in person to my counselor, or mailed to Children's After School Arts Attn: Lily Cardasis, 584 Castro St. #264, San Francisco CA, 94114.

This authorization is effective for one year from the date signed,
or until the following date: _____

_____

Parent/guardian signature *Date*