

570 West Crossville Road ● Unit # 104 ● Roswell, GA 30075

Phone: 404-547-0825 Fax: 770-783-6618 [www.brighthorizonstherapy.com](http://www.brighthorizonstherapy.com)

**HIPAA Authorization Form:**

***Notice of privacy practices as required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)***

**Child’s Name: (please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*This notice describes how health information about you and your child may be used and disclosed and how you can get access to your individually identifiable health information (IIHI).***

*I hereby authorize use or disclosure of protected health information about my child as described below:*

1. *OUR COMMITMENT TO YOUR PRIVACY:*

 Bright Horizons Pediatric Therapy, LLC is dedicated to maintaining the privacy of you and your

 child’s individually identifiable health information (IIHI). In conducting our business, we will

 create records regarding your child’s treatment and services we provide. We are

 required by law to maintain the confidentiality of health information that identifies you and

 your child.

**\*The terms of this notice apply to all records containing you and your child’s IIHI that are created or retained by Bright Horizons Pediatric Therapy, LLC. We reserve the right to revise or amend this notice of privacy practice at any time. Any revision or amendment to this notice will be effective for all your child’s records that Bright Horizons Pediatric Therapy, LLC has created or maintained in the past, and for any of your child’s records that we may create or maintain in the**

**future. You may request a copy of this notice at any time.**

1. *WE MAY USE AND DISCLOSE YOU/YOUR CHILD’S INDIVIDUALLY IDENTIFIABLE*

*HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:*

1. Bright Horizons Pediatric Therapy, LLC and its employees are authorized to use or disclose health information that is pertinent or required for speech & language therapy purposes.
2. Bright Horizons Pediatric Therapy, LLC may disclose health information considered pertinent to speech & language therapy to a patients physician, teacher, or other health care providers involved in their care.
3. I understand that Bright Horizons Pediatric Therapy, LLC will be disclosing protected health information to a patients physician, teacher, and other health care providers (when necessary) and also understand that the information used or disclosed may be subject to re-disclosure by the individual or facility receiving the information.
4. Bright Horizons Pediatric Therapy, LLC may use and disclose your IIHI in order to bill and collect payment for the services that we provided. We may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your child’s treatment to determine if your insurer will pay for your treatment. We may also use and disclose your IIHI to bill you directly for your child’s therapy services.

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1. Bright Horizons Pediatric Therapy, LLC may release your child’s IIHI to family members or friends that are involved in your child’s care (i.e. Grandparents, Aunts/Uncles, baby-sitter/nanny).
2. Bright Horizons Pediatric Therapy, LLC will use and disclose your IIHI when we are required to do so by federal, state or local law.
3. Bright Horizons Pediatric Therapy, LLC may disclose you and/or your child’s IIHI to appropriate authorities if we believe that your child is a victim of abuse or neglect. We may disclose your IIHI to the extent necessary to avert a serious threat to your child’s health or safety.
4. Bright Horizons Pediatric Therapy, LLC may use or disclose your IIHI to provide you with appointment reminders by contacting you via telephone, voicemail, e-mail or text.
5. *YOUR RIGHTS REGARDING YOU/YOUR CHILD’S IIHI:*
6. You may have the right to request that Bright Horizons Pediatric Therapy, LLC communicate with you about your child’s therapy in a certain manner or at a certain location (i.e. contact you at home rather than at work). In order to request a type of confidential communication, you must make a written request to Bright Horizons Pediatric Therapy, LLC: 3225 Shallowford Road NE, Bldg 1100, Ste 1120, Marietta, GA 30062-7030 specifying the requested method of contact, or the location in which you wish to be contacted. We will accommodate reasonable requests and you do not need to give a reason for the request.
7. You may have the right to request a restriction in our use of disclosure of you/your child’s IIHI for treatment, payment or care options. You also have the right to request that Bright Horizons Pediatric Therapy, LLC, restricts our disclosure of you/your child’s IIHI to only certain individuals involved in your child’s care or the payment for child’s care, such as family members or friends. We are not required to agree to your request; however if we do agree, we are bound by agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat your child. In order to request a restriction in Bright Horizons Pediatric Therapy, LLC’s disclosure of your IIHI, you must make your request in writing to: Bright Horizons Pediatric Therapy, LLC: 3225 Shallowford Road NE, Bldg 1100, Ste 1120, Marietta, GA 30062-7030
8. You may ask Bright Horizons Pediatric Therapy, LLC to amend your health information if you believe it is incorrect or incomplete. To request an amendment, please do so in writing to Bright Horizons Pediatric Therapy, LLC at 3225 Shallowford Road NE, Bldg 1100, Ste 1120, Marietta, GA 30062-7030
9. You are entitled to receive a paper copy of our notice or privacy practices. You may ask Bright Horizons Pediatric Therapy, LLC to give you a copy of this at ANY time.
10. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Bright Horizons Pediatric Therapy, LLC at 3225 Shallowford Road NE, Bldg 1100, Ste 1120, Marietta,GA 30062-7030. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
11. You may revoke this authorization by notifying ***Carmie Leister, MS, CCC-SLP*** and/or ***Bright Horizons Pediatric Therapy, LLC*** in writing of your desire to revoke it.
12. This authorization expires when a patient is discharged by Bright Horizons Pediatric Therapy, LLC or receives a written desire to revoke it.

IF YOU HAVE ANY QUESTIONS REGARDING THIS PRIVACY NOTICE, PLEAESE CONTACT:

 Bright Horizons Pediatric Therapy, LLC

 Attention: Carmie Leister, MS, CCC-SLP

 570 West Crossville Road

 Unit # 104

 Roswell, GA 30075

***\*Effective Date of This Privacy Notice: April 12, 2011***

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I am the parent/legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and have legal authority to make any health care decisions regarding this child.

As the parent/guardian of the above named patient, I authorize the following individuals to accompany my child to therapy and have access/knowledge of their health information.

**NAME: RELATIONSHIP:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Parent/Legal Guardian Signature Date