Brave Voices Counseling, LLC

**CHILD/ADOLESCENT REGISTRATION FORM**

Child’s Name:

Child’s Address:

Street City Zip code

Child’s Birth Date: \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Child’s Gender:  Male  Female

Father’s Name: Father’s Phone Number:

May we leave a message?  YES  NO

Father’s Email:

Mother’s Name: Mother’s Phone Number:

May we leave a message?  YES  NO

Mother’s Email:

**If parents are divorced, what are the custody arrangements for your child?**

***If one parent has primary custody, please bring custody paperwork***

***to your first session.***

**Brave Voices Counseling, LLC**

**Authorization for Use AND/OR Disclosure of Protected Health Information**

I authorize Brave Voices Counseling, LLC, to disclose and/or receive information from my child’s ‘**Emergency Contact**,’ person for whom I have listed below.

Emergency Contact Person

Relationship to Client

Phone Number (\_\_\_\_\_\_\_\_)

Street Address

City State: Zip Code

*I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.*

*I understand that I may revoke this authorization at any time by written request to Brave Voices Counseling, LLC.*

Child’s Printed Name:

Parent/Guardian’s Printed Name:

Parent/Guardian Signature:

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor’s Signature:

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brave Voices Counseling, LLC**

**Authorization for Use AND/OR Disclosure of Protected Health Information**

Client Name:

Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

I authorize Brave Voices Counseling to disclose and/or obtain medical information from my child’s medical provider for the purpose of providing continuity of quality mental health services.

**Medical Provider**:

Address:

Phone Number: (\_\_\_\_\_\_\_)

The authorization will expire in 1 year unless it is revoked.

*Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.*

*I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.*

Printed Name of the Client:

Signature of the Client:

Date:

Counselor’s Signature:

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”).

1. Tell your mental health professional if you don’t understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.