MICHELLE SOLOMON, M.A., CCC-SLP, PC

1430 2nd Ave #101
New York, NY 10021

HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

Child's Name:_____

1. Authorization

I authorize _____(therapist) to contact the following team members: (fill in the information for those individuals that we may contact to share your child' s progress and goals)

- Teachers_____
- Other SLP's_____
- Other therapists:
  - _____
  - _____
  - _____
  - _____
- Insurance Company
  - Company name_____
  - Policy Holder_____
  - ID Number_____

2. Effective Period

Authorization for sharing information covers the period of September 1, 2023 through August 31, 2024.

_____
Signature of parent

_____
Printed name of parent

Date_____