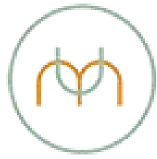

mommyu

AUTHORIZATION TO RELEASE INFORMATION

I, ___________________, as the ☐ parent ☐ legal guardian of ________________________,
(name) (choose one) (child's name)

Have agreed to work with ________________________, LCSW, certified Sleep Coach. As part of this process, I understand and acknowledge that she will exchange information with collaborative partners such as lactation specialists, pediatricians, and any other specialists identified.

The following information may be disclosed:

☐ Any information obtained during the course of providing sleep coaching services
☐ Information limited to: ____

____

____

This information may be shared by phone or in writing for the following purpose(s):

☐ treatment planning or coordination
☐ medical diagnosis by a licensed health professional retained by me
☐ other (**please specify**): ____

____

____

I understand that I may withdraw this consent at any time by giving notice in writing. If the person or entity receiving this information is not a health care provider or a health care plan covered by the Health Information Portability and Accountability Act ("HIPAA") or other privacy regulations, I understand that the person or entity may not be required to keep the information confidential.

This consent is valid for a period of ____________ (days/weeks/months/years) (**Please circle one**.)

____________________________ ______________________________
Parent/Guardian Parent/Guardian

____________________________ ______________________________
Date Date