



# Center for **B**iofeedback and **B**ehavior **T**herapy

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[www.cbbt.org](http://www.cbbt.org)

## **SIGNATURE FORM**

### **Permission for Treatment**

I consent to use the disclosure of my child's protected health information to carry out treatment, financial activity, and health care operations at the Center for Biofeedback and Behavior Therapy by the staff of the Center for Biofeedback and Behavior Therapy. I understand I have the right to read the Center for Biofeedback and Behavior Therapy's Notice of Privacy Practices before deciding to sign below. This notice is available upon request at the Center for Biofeedback and Behavior Therapy. I give permission for the Center for Biofeedback and Behavior Therapy to mail information to my home or send information to me electronically, or other designated location. I also give permission to be contacted at provided phone numbers and to leave a message on the voice mail.

### **Permission for Testing**

I give permission for an assessment to be made of my child's attention functions, social and/or psychological behavior. I understand that this assessment may involve examination of records and reports (provided by the parent or sent at the request of the parent), gathering of developmental, educational, and social information by parent report and parent rating scales. I understand that a parent conference will subsequently be held in which the findings and recommendations of this assessment will be discussed.

I understand that all information will be handled in confidence and release will be limited to authorized personnel and/or to others I have designated by signing the release of information included in this packet.

Patient's Name (please print) \_\_\_\_\_

Guardian's signature: \_\_\_\_\_

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

Are you the legal guardian of this child? \_\_\_\_\_