Declination of Consent for Collaboration

I, _____ (client/parent/guardian), DO NOT authorize Harmony House ABA to share, obtain, or exchange any information with external professionals or service providers including but not limited to schools, medical providers, therapists, or social service agencies.

I understand that by declining collaboration, coordination of care between providers may be limited, which could impact the effectiveness or continuity of services.

Acknowledgment

I understand that:
- This decision is voluntary and I may choose to provide consent for collaboration at any time in the future.
- Declining consent will not affect my right to receive services from Harmony House ABA. - Harmony House ABA will continue to maintain confidentiality in accordance with HIPAA and applicable laws.

Signatures

Client/Guardian Name: _____

Signature: _____