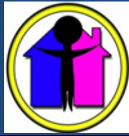

www.childreninthemiddle.com
Office (800) 239-3971
Fax (972) 704-2912
Support@childreninthemiddle.com

INSTRUCTIONS FOR COMPLETING THE MENTAL HEALTH PROFESSIONAL AUTHORIZATION FOR USE AND RELEASE OF INFORMATION

1. Complete a separate release for each mental health professional listed on your personal data form.
2. After "To;" fill in the full name of the mental health professional including the professional's professional initials.
3. After "Client(s):" fill in the first line with your name (even if your child was the client) and if the mental health professional saw your child, write in their name below yours on the lines provided. After each name fill in the following line with the individual's date of birth.
4. On the bottom line, sign your name, print your name, your relationship to the client (either "self", and "father" or "mother") then put the date you signed it.

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Authorization for Use and Release of Information

To: ____
Client(s): ______________________________ DOB: ________________
______________________________________ DOB: ________________
______________________________________ DOB: ________________

The undersigned hereby authorizes Bradley S. Craig, LMSW-IPR, CFLE and the PC communication coach to obtain from the above named person or organization any and all information about the above client(s) in the following areas:

☐ medical	X discharge summaries	X counseling/therapy	☐ police records
☐ dental	☐ admissions summaries	X psychiatric/mental health	X CPS records
☐ school	X psychotherapy notes	X psychological evaluations	X social history
☐ day care	☐ probation/parole	X Parenting coordination	X Custody Evaluation

X Alcohol and drug abuse treatment records (including those covered under 42 CFR part 2)
X Any and all HIV/AIDS related conditions and testing

The person signing this form will be responsible for any fees incurred for this request.

The purpose of this disclosure of information is for parenting coordination services to improve assessment and service planning, share information relevant to services requested by clients, and, when appropriate, coordinate services. I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected. I understand services or payment cannot be conditioned on signing this authorization.

HIPAA Statement: I understand information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected. I understand services, treatment or payment cannot be conditioned on signing this authorization.

I acknowledge that this authorization may be revoked via written notice at any time by sending notification to Mr. Craig. I understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. This release is effective for one year from date signed unless otherwise revoked. A photo copy or fax of this authorization is as valid as the original.

I acknowledge I was offered a copy of this authorization for my records.

____

Signature Printed Name Relationship to client(s) Date