Between Two Homes®, LLC
www.childreninthemiddle.com
Office (800) 239-3971
Fax (972) 704-2912
Support@childreninthemiddle.com

INSTRUCTIONS FOR COMPLETING THE MEDICAL PROFESSIONAL AUTHORIZATION FOR USE AND RELEASE OF INFORMATION

1. Complete a separate release for each medical professional, hospital, or clinic listed on your personal data form.
2. After “To;” fill in the full name of the medical professional, hospital, or clinic.
3. After “Client(s):” fill in the first line with your name (even if your child was the client) and if the medical professional, hospital, or clinic provided services to 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 PF communication coach to disclose to and/or obtain from the above named person or organization any and all information about the above client(s) in the following areas:

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

I acknowledge that unless they specifically request in writing that the disclosure be made in a certain format Mr. Craig reserves the right to disclose information as permitted by the authorization in any manner that he deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

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 at the above information. 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