Pediatric Psychological Services

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CONSENT TO RELEASE AND/OR OBTAIN CONFIDENTIAL INFORMATION

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____

Check all that apply:

☐ Release Information to: ☐ Obtain Information from:

Name/Facility: _____ Attention: _____

Address: _____

Phone: _____ Fax: _____

Information to Release/Send:

☐ Evaluation Results ☐Educational Records/Information

☐ Treatment Information ☐Other: _____

Purpose of Disclosure:

☐Evaluation ☐Treatment ☐Legal ☐Other:

_____

I, the undersigned patient or legal representative, hereby authorized the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse, and HIV related information.

- I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.
- I understand that I have a right to revoke this authorization; I must do so in writing and present my written revocation to Pediatric Psychological Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise noted or revoked, this authorization will expire 1 year from the date of signing.

_____ _____ _____

Parent or Guardian (print) Signature Date