

**AUTHORIZATION TO RELEASE INFORMATION FORM**

Individual’s Name: Date of Birth:

Individual’s Social Security Number:

I hereby authorize PAMCO CARE NC, LLC to:

\_\_\_\_\_ obtain from the following \_\_\_\_\_ release to the following

Name:

the following documents/information from the records pertaining to services received

\_\_\_ Admission/Discharge Summary

\_\_\_ Diagnostic/Medical Evaluations

\_\_\_ Medical Test Results

\_\_\_ Psychological Evaluations

\_\_\_Service Plans and Treatment Summary

\_\_\_ Social History

\_\_\_ OT/PT/ST/ ED Evaluations

\_\_\_ Progress Notes

\_\_\_ Other

The records are required for the specific purpose of: Service Coordination

I understand that my authorization will remain effective from the date of my signature until:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Date