RELEASE TO DISCLOSE CONFIDENTIAL INFORMATION

PATIENT: _____ DOB: _____

This form allows you to provide information from current/past providers TO Children's Program to coordinate care/treatment/evaluations done in the past. It also gives permission for information about your treatment/evaluations at Children's Program to be sent to new/current providers you are seeing.

This authorization will expire 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose. You have the right to revoke this Authorization at any time in writing to your clinician or our clinic administrator. Identify the date you signed the Authorization, the recipient of the information identified, and state that you are revoking the Authorization. We cannot take back uses or reverse disclosures already made with your permission.

I have reviewed and I understand this Authorization. By signing this, I understand that I am directing you to disclose information to /receive information from a person or organization that may not have or obey the same obligations to protect privacy under state and federal law. The disclosure of the information specified above carries with it the potential of an unauthorized re-disclosure and loss of protection under state and federal law.

Communication by electronic means, i.e., Fax or E-mail, is not secure and presents a significant risk to patient confidentiality. By requesting exchange of information or communication by E-Mail or by Fax I acknowledge that I am aware of these significant additional risks to confidentiality and agree to assume these risks and know that confidentiality, review, re-disclosure, dissemination, distribution or copying of this information cannot

I authorize _____ to **PROVIDE** information/records to the Children's
(Facility/Provider/School)

Program regarding _____ By: ☐ Mail ☐ E-mail ☐ Fax ☐ Telephone
(child's name)

_____
(Please list specific information requested.)

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I authorize Children's Program to **RELEASE** information to: _____
(Facility/Provider/School)

By: ☐ mail ☐ E-mail ☐ Fax ☐ Telephone

_____
Mailing Address (must be complete to be processed)

_____ _____ _____
E-mail Address Telephone Fax number

YOU MUST BE SPECIFIC regarding the information you are releasing.

- ☐ Developmental Pediatric Report/Chart Note (s): _____
- ☐ Psychological Report (s): _____
- ☐ Psychological Treatment Summary: _____
- ☐ Other: _____

(Please see the Confidentiality section of your Treatment Consent form regarding the release of chart notes.)

_____ _____
Signature of Client (ages 14 or older) Date

_____ _____
Signature of parent/guardian (for clients younger than 14 years) Date

REQUESTS FOR A COMPLETE CHART WILL INCUR A MINIMUM CHARGE OF $25. PLEASE INCLUDE YOUR TELEPHONE NUMBER AND WE WILL CALL YOU FOR PAYMENT INFORMATION.

Phone: _____

Childrens Program
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