CONSENT TO RELEASE RECORDS

We understand that information about your child is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your child's protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION:

You must answer the questions below completely. DO NOT SIGN A BLANK FORM. You should read the descriptions below before signing this form.

Patient Name _____

WHO WILL USE/RECEIVE THE SPECIFIED INFORMATION?

Contact Name _____

Name of School or Organization _____

Address _____

City _____ State _____

Zip _____ Phone (____) _____

WHAT INFORMATION WILL BE SHARED (please check all that apply)?

- ☐ telephone consultation
- ☐ progress notes
- ☐ evaluation reports
- ☐ videotapes
- ☐ billing statements
- ☐ other (please specify _____)

Please turn over to complete back of form.

By signing this authorization form, you authorize the use or disclosure of your child's protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.

You have a right to see and copy the information described on this authorization form in accordance with our record access policies. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that we have already taken action based upon your authorization. To revoke this authorization, please write to Jill E Senner.

SIGNATURE
I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____
Signature of Parent or Legal Guardian

_____
Print Name of Patient

_____
Date

CONTACT INFORMATION
The contact information of the parent or legal guardian who signed this form should be filled in below.

Address:

_____
_____
_____
_____

Telephone:
_____ (daytime)
_____ (evening)

Email Address (optional):

Expiration Date _____