RELEASE OF INFORMATION FOR MINORS

Name of Child (Patient): _____ Date of Birth: __/___/____

My Name: _____
Relationship to Child: _____
On behalf of the patient, for whom I am a legal guardian of, I authorize
_____ whose office is located
at_____, to disclose and/or obtain treatment information
from the following physician, psychiatrist, teacher, or any other person I choose to name below:

Contact Person's Name: _____
Address: _____
Phone: _____ E-mail: _____

I agree to the release of all of this patient's Protected Health Information (PHI), including:

_____All Protected Health Information (PHI)
____Mental Health Diagnosis
____Progress Notes
____Treatment Plan
____Medication Records
____Discharge Summary
____Neuropsychological Assessment or Academic Testing Results
____Substance Abuse Information

By signing below I acknowledge that the above information about the patient may be released, discussed, and/or disclosed. I understand that their records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present a written revocation. Unless otherwise revoked, this consent expires in 12 months from the date signed. I understand that once information is disclosed as per my authorization, the recipient, in accordance with applicable laws and regulations, may redisclose the information and it might not be protected by federal or state privacy regulations.

Signature of Legal Guardian/Parent: _____

Date Signed: _____

Signature of Witness: _____

Printed Name of Witness: _____