kiddotherapy LLC

Consent for Release of Medical Information

Patient_____Date of Birth_____
This is to authorize that the information regarding the above individual be forwarded by mail, fax, or phone.

FROM: (Name and address of facility from which information is being requested)

_____

_____

BE SENT OR GIVEN TO: (Name and address of facility, attorney, insurance company, or person information is being released to)

_____

_____

REASON FOR REQUEST: (Continuing care, investigation, personal)

_____

INFORMATION REQUESTED: (Specifics as to part of record requested; or, if complete chart, dates of treatment)

_____

I acknowledge that information to be released may include alcohol and/or psychiatric information that is protected by Federal regulations. My signature authorizes release of such information.

_____ _____
Signature of Patient/Parent/Patient Representative Signature of Witness

_____
Date Time

This content is subject to revocation by the patient at any time, in writing, except to the extent that action has been take in reliance hereon. This consent will terminate 1 year from the date listed above.

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