Authorization to Release Records

This form, when completed and signed by you, authorizes us to exchange protected information from your clinical record to the person you designate. For example, you may want us to send a copy of the evaluation findings to your child's pediatrician or other professional(s), or school.

Child's Name: ______________________________ DOB: __________

I authorize FDH and/or the administrative and clinical staff to send a copy of my child's evaluation and/or progress notes to the following individual(s) :

Name: ____

Address: ____

____

Fax #: ____

This information should only be exchanged with: ________________________

____

I am requesting Foundations Developmental House to exchange this information for the following reasons: evaluation, educational and treatment planning.

You have the right to revoke this authorization, in writing, at any time, by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

____

Signature of Parent or Guardian (specify) Date