PARKER PEDIATRICS & ADOLESCENTS, P.C.

Serving the Parker community since 1982

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AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I (we), _____, authorize
(Name(s) of Parent or Guardian]

Parker Pediatrics & Adolescents, P.C. to release, obtain, and/or exchange, information regarding:

(Parent/Guardian should initial each item to be release and/or obtained)

_____ Psychological Assessment
_____ Psychological Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Toxicological Reports/Drug Screens
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Other: _____
_____ Other: _____

About my child:

Child Name _____ Child Date of Birth _____

Facility to release information to/from

(name of child's doctor, school, clinic, hospital, etc.)
(Street Address)
(City) (State) (Zip Code)
(Telephone) (Fax)
(Email)

If you do not want certain parts of your records released, please initial the lines beside the type of information you do not want released. Otherwise, your records will be released as specified above.

_____ Substance Abuse, if any
_____ AIDS/HIV, if any
_____ Other: _____

I understand that the purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I understand that I may revoke this authorization, in writing, at any time by sending written notification to Parker Pediatrics & Adolescents, P.C. at 10371 Parkglenn Way, Suite 100, Parker, CO 80138. I also understand that unless I specify an earlier date it will automatically expire one year from the date below. I understand that if Parker Pediatrics & Adolescents, P.C. has released information based on this authorization before I revoke it, Parker Pediatrics & Adolescents, P.C. cannot get the information back. I also understand that Parker Pediatrics & Adolescents, P.C. has no control over information released to anyone else and that those recipients may disclose such information. I understand that a copy of this authorization may be used in place of the original. I understand that authorizing the disclosure of this health information is voluntary. I need not sign the form to ensure treatment. I understand that I can inspect the information to be disclosed. I will be given a copy of this authorization for my records.

Signed _____ Date _____
Signature of Patient

Signed _____ Date _____
Signature of Parent, Guardian or Personal Representative (if applicable)

Signed _____ Date _____
Representative of Parker Pediatrics & Adolescents, P.C.