Pediatric Associates, Inc.

**1021 Country Club Rd.**
**Whitehall, OH 43213**
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**Behavioral Health Services**

**Permission for Release/Request of Confidential Information**

To: _____
Name of healthcare provider/physician/facility/individual

_____
Street address, City, State, Zip

Re: _____ _____
Patient name Date of Birth

I, the parent or guardian, hereby authorize Pediatric Associates, Inc. and the individual or facility above to exchange information.

**The type of information to be disclosed:**
**All Information: _____**
*Specific Information: (check below)*
Evaluations _____ Medical Records _____ Diagnosis _____ Treatment Plan _____ Psychological/Medical Test Results _____ Mental Health Record Summary _____ Course of Treatment _____ Psychotherapy Notes _____ Other
_____

*Exceptions:* _____

**The purpose of such disclosure:**
Ongoing Treatment _____ Medical Care _____ Consultation _____ Evaluation _____ Transfer _____ Legal issues _____ Coordination of Care _____ Health Benefit Utilization _____ Other _____

**Dates of records requested:** _____

This consent is in effect until _____. I understand that I may revoke this authorization, in writing, at any time unless resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization with certain exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children. I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations. I also understand that a fee may be associated with the release of my records, and that my records may not be released until I, or the responsible party, pay the fee. Furthermore, I recognize that my records may not be released if I have an outstanding balance with Pediatric Associates, Inc. and until the balance is paid. This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if know, have been explained to me.

_____ _____
Patient/Guardian signature Date

_____ _____
Patient 12-17 years old signature Date

_____ _____
Clinician/Witness Signature Date