Behavioral Health Services

Permission for Release/Request/Exchange of Confidential Information

Re: ___________________________________ ____
Patient name Date of Birth

I, the patient or guardian, hereby authorize Pediatric Associates, Inc. to exchange information, as outlined below, with the following individual, clinic, or facility:

____
Name of the individual, clinic, or facility

_______________________ ____
Phone Number Street address, City, State, Zip

The type of information to be disclosed:
All Relevant Information: ______
Specific Information: (check below)
Diagnosis _____ Treatment Plan _____ Behavioral Health Treatment Summary _____
Progress Notes _____ Other _______________________
Exceptions: ____

The purpose of such disclosure:
Coordination of Care _____ Consultation _____ Transfer _____ Legal issues _____ Other _______________

Dates of records requested: All Dates of Service_______ Specific Dates (list dates or date range) ___________

This consent is in effect for 1 year, unless otherwise specified. I understand that I may revoke this authorization, in writing, at any time. 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 abuse 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 known, have been explained to me.

____ ___________
Patient/Guardian signature Date

____ ___________
Patient 12-17 years old signature Date

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION