EARLY CHILDHOOD Wellness place

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Authorization to Release Information

I, _____(Parent/Guardian name),, hereby authorize the mutual exchange of

information between **Julia Morrison, MSW Intern** and _____(Name of person/organization or Pediatrician/Office). Ph#_____

CHILD'S NAME: _____

Information to be released includes: (check mark or place letter X next to each)

- ☐ Social History
- ☐ Psychological Reports or Evaluations
- ☐ Psychiatric History
- ☐ Protected Health Information (if checked, this must be a consent for release of PHI only)
- ☐ Legal History
- ☐ Treatment Goals
- ☐ Medical History
- ☐ Other_____

Information is released for the purpose of: (check mark or place letter X next to each)

- ☐ Continuity of Care
- ☐ Service Planning
- ☐ Assessment
- ☐ Legal Purposes
- ☐ Other_____

I understand that my records are protected under specific federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it (e.g. the provision of treatment upon consent to disclosure to third party players) and that in any event this consent expires automatically as described below.
This authorization of exchange of information is valid for one year from the date of signature.

I understand that information used or disclosed pursuant to this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by the HIPAA privacy rule. I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

Parent / Guardian Printed name: _____

Signature: _____ **Date:**_____

Child (Minor 12yrs + Only) Printed Name: _____

Child (Minor 12yrs + Only) Signature: _____ **Date:**_____

Provider's Signature: _____ **Date:** _____