Medical Information Release Form

(HIPAA Release Form)

Release of Information

_____ Date of Birth _____/_____/_____

Child's Name

_____ _____

Parent's Name Relationship to Child

[ ] I authorize the **release of information** including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

	NAME	ADDRESS/EMAIL	PHONE
Pediatrician			
Teacher			
Therapist/s (OT, PT, ABA)			
Other			

[ ] Information is **not to be released** to anyone.

[ ] I authorize **photos and/or videos** of my child for **clinical use only.**

This **Release of Information** will remain in effect until terminated by me in writing.

Signed:_____

Date:_____

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