**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_ /\_\_\_\_ /\_\_\_\_

**I authorize [INSERT PRACTICE NAME] to exchange health information about my child with the providers and agencies I have listed below for the purpose of care coordination, evaluation, diagnosis, and/or treatment.**

Including the following information: Medical Educational Social Mental Health

 Screening Reports

The following methods are acceptable to me (check all that apply):

 Written Verbal Electronic (email)

|  |  |  |
| --- | --- | --- |
| **Contact or Resource**  | **Resource Name/Address** | If revision,Initial & date |
| Other Physicians |  |  |
| School or Educational Services |  |  |
| Developmental Services, CIS-EI or EEE |  |  |
| Therapy Services (PT, OT, Speech Therapist) |  |  |
| Mental Health Services |  |  |
| Home Health, VNA, orCIS-Nursing & Family Support |  |  |
| Other, e.g., WIC |  |  |
| Other |  |  |

**I understand that:**

* I have the right to *withdraw or modify* this authorization at any time by submitting a written notice to the [INSERT APPROPRIATE OFFICE OR INDIVIDUAL]. This will not affect information sharing that already occurred on the basis of this authorization
* *I may refuse to sign this authorization*. Such refusal will not affect services that I may receive from [INSERT PRACTICE NAME]
* I may inspect or copy the protected health information described by this authorization, except in the case of confidential adolescent health information

**Expiration Date:**

* This release will expire on \_\_\_\_ /\_\_\_\_ /\_\_\_\_, or

*If no date is stated, expiration is 2 years from date signed.*

**Signature** **Date** \_\_\_\_ /\_\_\_\_ /\_\_\_\_

**Printed Name**

**Relationship to Patient**