

# Pediatric Behavioral Health, LLC

## Release of Information

I hereby authorize an exchange of the following protected information of:

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Between: Pediatric Behavioral Health and \_\_\_\_\_  
148 Worcester St. \_\_\_\_\_  
West Boylston, MA 01583 \_\_\_\_\_  
Phone: (508) 835-1735 Fax: (508) 835-1736 \_\_\_\_\_

PURPOSE OF RELEASE: Coordination of Care \_\_\_\_\_

### SPECIFIC INFORMATION TO BE RELEASED:

- |  |  |
|--|--|
| <input type="checkbox"/> History and Physical                | <input type="checkbox"/> Social / Emotional / Academic Functioning at School |
| <input type="checkbox"/> Psychiatric Records                 | <input type="checkbox"/> School Attendance Records                           |
| <input type="checkbox"/> Outpatient Treatment Notes          | <input type="checkbox"/> Psychological and / or Educational Evaluations      |
| <input type="checkbox"/> Phone Communication between parties | <input type="checkbox"/> IEP Plans   |
| <input type="checkbox"/> Other (specify) _____               |  |

DATES: Covered by this authorization are from: \_\_\_\_\_ to \_\_\_\_\_

It is my understanding that this information will be used solely for the purpose described above. I understand that the information which I am authorizing to be released may include psychiatric diagnoses and or drug/alcohol related information.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy rule.

I understand that I may revoke my permission in writing at any time. Any actions Pediatric Behavioral Health, LLC may have taken before receiving notice that the consent has been revoked would not be covered by the revocation. I hereby release Pediatric Behavioral Health, LLC and its duly authorized agents from all legal responsibility or liability for the release of information indicated and authorized herein.

I understand that my care provider generally may not condition mental health services upon my signing an authorization unless the mental health services are provided for the purpose of creating health information for a third party.

A fax or photocopy of this form is considered valid.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relation to Patient:  Parent  Legal Guardian  Foster Parent  Other \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_