RELEASE OF INFORMATION CONSENT

I authorize Bold Pediatric Therapy Center to release/receive protected health information on the following patient:

______________________________ _________________

(Patient Name) Date of birth

To / From:

Name of Agency/person: ____

Address: ____________________________________

City: _____________ State: _____ Zip:____________

Phone: _________________ Fax: __________________________

Check all that apply:

__ Academic testing
__ Behavior programs
__ Case notes
__ Intelligence testing
__ Medical reports
__ Personality profiles
__ Progress reports
__ Therapy Assessments
__ Psychological testing
__ Service plans
__ Summary reports
__ Vocational testing
__ Entire record
__ Other (specify):

____

The above information will be used for the following purposes:

___ To develop a treatment plan / Continuity of care

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Signature: __________________________ Relation to patient:_________________

Printed name: ______________________________ Date: _____/____/______