Authorization Release of Information (Child/Adolescent)

Patient Name: _______________________________ Date of Birth: _____________

- Psychiatric or mental health name/contact: ___________________________
- Psychiatric contact email: ____
- Psychiatric contact phone number: _________________________________

Please circle one: All records Verbal communication Copy of documents

- Physician/ Other Helping Professional name: ____________________________
- Physician/OHP email: ____
- Physician/OHP phone number: _____________________________________

Please circle one: All records Verbal communication Copy of documents

- Therapist name/contact: ______________________________________
- Therapist email: ____
- Therapist phone number: _____________________________________

Please circle one: All records Verbal communication Copy of documents

- School name/contact: ______________________________________
- School email: ____
- School phone number: _____________________________________

Please circle one: All records Verbal communication Copy of documents

- Other contact name/relationship: ___________________________________
- Phone number: ____

Please circle one: All records Verbal communication Copy of documents

I, ____, hereby consent to the exchange of clinical/medical/ records or other confidential information between HTFG and the following providers. The purpose for this release is for treatment team planning. This authorization can be revoked at any time by any party above and HTFG.

____________________________________ _____________________
Clinician Name (print) Clinician contact

____________________________________ ____________________
Parent/Legal Guardians Signature date

[Type text]