Emerge
Professionals in Autism, Behavior & Personal Growth

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Standard Consent to Request/Release Medical Information

I, _____
(Parent/Client's Name) First MI Last

Hereby authorize Emerge, P.C. to obtain or release copies of my or _____
Child's Name

medical records from/to:_____
Name of Agency/Organization/Person

_____
Agency/Organization's Mailing Address City/State/Zip

_____ _____ _____
Agency/Organization Phone Fax Email

_____ _____ _____
Client's Date of Birth SSN# Approximate Dates of Treatment

Purpose(s) or need for which information is to be used:

( ) Continuity of Care
( ) Verbal exchange of information only for Continuity of Care (Valid for one year from date of Signature).
( ) Other_____

Specific information to be released:

( ) Psychosocial History
( ) Educational Records/IEP's
( ) Consultations/Intake Summary
( ) Treatment/Individual Service Plan(s)/Behavior Support Plan(s)
( ) Medical Records:
- ( ) Developmental History
- ( ) Neurological History
- ( ) Medication History
- ( ) Other_____

( ) Progress Report(s)
( ) Discharge Summary/After Care Plan
( ) Psychological/Behavioral Evaluations
( ) Other: _____
( ) Physical Examination
( ) Psychiatric History
( ) Laboratory Data

I understand that information to be released may include information regarding the following condition:
( ) Psychiatric Conditions

Authorization

I hereby certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has been taken to comply with it. I understand that this consent will expire _____ or if left blank, in 90 days, except in the instance of verbal exchange only for Continuity of Care. I hereby release Emerge, P.C. and its representatives from any liability which may result from furnishing the information requested as authorized in this release.

A copy of this authorization is to be considered as valid as the original.

_____ _____
Client Signature **Date**

_____ _____
Signature of Parent/Legal Guardian (of minor) **Date**