

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: <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Verbal exchange of information only for Continuity of Care (Valid for one year from date of Signature). <input type="checkbox"/> Other _____	
Specific information to be released: <input type="checkbox"/> Psychosocial History <input type="checkbox"/> Progress Report(s) <input type="checkbox"/> Educational Records/IEP's <input type="checkbox"/> Discharge Summary/After Care Plan <input type="checkbox"/> Consultations/Intake Summary <input type="checkbox"/> Psychological/Behavioral Evaluations <input type="checkbox"/> Treatment/Individual Service Plan(s)/Behavior Support Plan(s) <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Restrictions	
<input type="checkbox"/> Medical Records: <input type="checkbox"/> Developmental History <input type="checkbox"/> Physical Examination <input type="checkbox"/> Neurological History <input type="checkbox"/> Psychiatric History <input type="checkbox"/> Medication History <input type="checkbox"/> Laboratory Data <input type="checkbox"/> Other _____	
I understand that information to be released may include information regarding the following condition: <input type="checkbox"/> Psychiatric Conditions	
<p>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 1 year. 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.</p> <p>A copy of this authorization is to be considered as valid as the original.</p>	
_____ Client Signature	_____ Date
_____ Signature of Parent/Legal Guardian (of minor)	_____ Date