Emerge
Professionals in Autism, Behavior & Personal Growth

400 South Colorado Blvd, Suite 400, Glendale, CO 80246
Phone: 303.322.9000 – Fax: 303.322.9001
info@emergeprofessionals.com

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)
( ) No Restrictions
( ) Medical Records:
- ( ) Developmental History
- ( ) Neurological History
- ( ) Medication History
- ( ) Other________________________________
- ( ) Physical Examination
- ( ) Psychiatric History
- ( ) Laboratory Data

( ) Progress Report(s)
( ) Discharge Summary/After Care Plan
( ) Psychological/Behavioral Evaluations
( ) Other: ______________________________

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 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.

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**