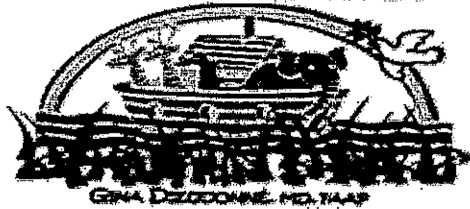
RAINBOW PEDIATRIC P.C.



CONSENT AND AUTHORIZATION TO RELEASE INFORMATION OR HEALTH RECORDS UNDER PROTECTION OF FEDERAL LAW TITLE 42, CFR CHAPTER 11 PART 11

PATIENT NAME:______________________________ PHONE NUMBER:____________________
LAST FIRST MI

BIRTH DATE:__/__/__ SOCIAL SECURITY NO:____________________ SEX:______________

PARENT/GUARDIAN NAME:____
LAST FIRST

PURSUANT TO FEDERAL GUIDELINES CONCENING MY RIGHT TO CONFIDENTIALITY, I ____________________
NAME OF PATIENT

AUTHORIZE RAINBOW PEDIATRIC TO RELEASE MY HEALTH RECORDS OF INFORMATION CONCERNING MY HEALTH RECORDS TO ____
NAME OF SPECIFIC PERSON OR ORGANIZATION

I SPECIFICALLY COSENT ONLY TO THE RELEASE OF INFORMATION OR HEALTH RECORDS PERTAINING TO:

THE FOLLOWING INFORMATION:__BEHAVIORAL __MEDICAL __DENTAL __ALL THE BELOW

__PRIOR ASSESSMENTS __RECOMMENDATIONS __CLOSING SUMMARIES

__PROGRESS NOTES __TREATMENT PROVIDED __MEDICAL

__OPINIONS REGARDING PARENT COMPETENCE

__OTHER RELEVANT INFORMATION, MEDICAL OR PSYCHOLOGICAL

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT TO RELEASE OF INFORMATION AT ANY TIME: HOWEVER, I ALSO UNDERSTAND THAT ANY RELEASE WHICH HAS BEEN MADE PRIOR TO MY REVOCATION AND WHICH WAS MADE IN RELIANCE UPON THIS AUTHORIZATION SHALL NOT CONSTITUTE A BREACH OF MY RIGHT TO CONFIDENTIALITY. UNLESS I REVOKE THIS AUTHORIZATION PRIOR TO SUCH TIME, THIS AUTHORIZATION TO RELEASE INFORMATION SHALL EXPIRE WHEN:____
(DATE, EVENT, CONDITION, OR EXPIRATION)

AT THAT TIME NO EXPRESS REVOCATION SHALL BE NEEDED TO TERMINATE MY CONSENT: HOWEVER REVOCATION OF CONSENT AT ANY OTHER TIME MUST BE PROVIDED IN WRITING:

______________________________ ______________________________
PARENT/GUARDIAN SIGNATURE DATE WITNESS DATE

A YOUTH AGED 16 OR OLDER MAY SIGN FOR THEMSELVES: THE CASE MANAGER OR FOSTER PARENT MAY SIGN FOR ANY CUSTODIAL YOUTH IN THEIR CARE.

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Revised 4/16/14