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CONSENT & AUTHORIZATION TO RELEASE INFORMATION (Child)

Pursuant to federal guidelines concerning my right to confidentiality,

I, ______________________________ authorize
(Parent or Guardian)

____ to release my child's
(Specific person or organization)

______________________ Date of Birth: ______________
(Name of Child)

medical records or information concerning such medical records, psychological records, and other evaluative reports to:

____
(Name of specific person or organization)

I specifically consent only to the release of information or medical records pertaining to:

____

____
(Specific nature, reason for, and extent of information released)

I understand that I may revoke this consent to release 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 breech of the right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when:

____
(State date, event, or condition of expiration)

At any time, no express revocation shall be needed to terminate my consent.

Signed__________________________ Date___________

Witness_________________________ Date___________