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Request/Authorization to release confidential records and information

I hereby authorize Dover Pediatrics, PLLC to exchange (*send and receive*) information

about _____, born on _____,

With the following person or facility:

Address: _____

Phone: _____

For the following purpose(s):

- Further mental health evaluation, treatment, or care
- Treatment planning
- Other: _____

These records concern the time between _____ and _____.

The information to be disclosed is so identified by an X below:

- Medical history and evaluation(s)
- Mental health evaluations
- Developmental and/or social history
- Educational records
- Substance use history
- Progress notes, and treatment or closing summary
- Other: _____

I have had the above information explained to me and fully understand that this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. I understand that this consent to share information is valid for one year from the date signed below and I can revoke it at any time with a written request.

Parent/Guardian/Self

Date