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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 or Self Date