



CONSENT FOR RELEASE OF INFORMATION

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, give consent for  
The Fort Christian Psychiatric Center to receive my child's protected health information from and release it to:

Name of person / facility to receive my child's information: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

The request and authorization applies only to the following information:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Medical History/Physical Exam | <input checked="" type="checkbox"/> Laboratory Test Results | <input type="checkbox"/> Consultation Reports    |
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> Summary of Hospitalizations        | <input type="checkbox"/> Progress Notes          |
| <input type="checkbox"/> Psychiatric Reports/Tests     | <input type="checkbox"/> Psychological Reports/Tests        | <input type="checkbox"/> Teachers' Reports       |
| <input type="checkbox"/> Psychiatric Evaluation        | <input type="checkbox"/> Medication History                 | <input type="checkbox"/> IEP/504 Plan            |
| <input type="checkbox"/> Treatment Recommendations     | <input type="checkbox"/> Course of Treatment                | <input checked="" type="checkbox"/> Fasting Labs |

Other: Baseline (and future routine) fasting labs. Lab order accompanied with this ROI Form.

The purpose of the release of information is:  Collaboration of Care  Continuation of Care

The release will remain in effect indefinitely, unless otherwise specified by you.

I understand that I can cancel this authorization at any time, except for action that has already been taken.

\_\_\_\_\_  
Signature of Patient (18 years and older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date