Pediatrics Unlimited

Be The Best You Can BEE With Therapy

Authorization To Release Health and/or Psychological Information

I, _____, authorize the release/disclosure of the information originated by Pediatrics Unlimited Inc. I understand information may be mailed or faxed or electronically transmitted when necessary. I understand that this authorization may last up to one year but can revoked verbally or in writing by the authorized person.

[ ] I understand that psychological records may include reference to psychiatric care, sexual assault, alcohol abuse and/or drug abuse.

[ ] I understand that electronic transmission of information includes email, instant messaging and web-based video conferencing. Email is frequently the most efficient way for school and Pediatrics Unlimited staff to communicate between agency providers. The limitation of electronic transmission of information is that we cannot ultimately guarantee their security. Precautions will include initial verification of email addresses and online identities before clinical information is transmitted.

Any specific information NOT to be released may be listed here _____

_____

Patient Information:

Name _____ Date of Birth _____

Release information to:

Pediatrician _____ Other (school, ENT, Babynet, anyone that may bring child to therapy, etc.) _____

Office Name _____ Telephone Number _____

Neurologist _____ Other (school, ENT, Babynet, anyone that may bring child to therapy, etc.) _____

Office Name _____ Telephone Number _____

Dev. Pediatrician _____ Other (school, ENT, Babynet, anyone that may bring child to therapy, etc.) _____

Office Name _____ Telephone Number _____

Orthopedist _____ Other (school, ENT, Babynet, anyone that may bring child to therapy, etc.) _____

Office Name _____ Telephone Number _____

Other Doctor _____ Other (school, ENT, Babynet, anyone that may bring child to therapy, etc.) _____

Office Name _____ Telephone Number _____

Signature _____ Relationship to Patient _____ Date _____

Witness _____ Date _____

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