



Authorization for Release of Information

KidsPeace Corporations and its subsidiary corporations

(All parts of this form must be completed in compliance with applicable Federal and State regulations.)

Client Name: _____ D.O.B.: _____

PA#: _____ MR#: _____

I hereby authorize **KIDSPEACE** _____ to exchange information with:
(Program)

Name: _____ Phone #: _____

Address: _____

for the purpose of: _____

The information to be **RELEASED** is:

- Psychiatric Evaluation Lab Reports Medications Treatment Plans
- Medical History Psychological Evaluation Dental History Integrated Summary
- Biopsychosocial Assessment Academic Evaluation Individual Education Plan Substance Abuse Information * _____
- Discharge Summary Discharge/Aftercare Plans Immunization Records ***Client initials required to release substance-abuse related documents.**
- Other (specify) _____

The information to be **OBTAINED** is:

- Psychiatric Evaluation Lab Reports Medications Treatment Plans
- Medical History Psychological Evaluation Dental History Integrated Summary
- Biopsychosocial Assessment Academic Evaluation Individual Education Plan Substance Abuse Information * _____
- Discharge Summary Discharge/Aftercare Plans Immunization Records ***Client initials required to release substance-abuse related documents.**
- Other (specify) _____

HIV-related information contained in the parts of the record indicated above will not be released through this consent. A separate consent is required in order to release HIV-related information.

I have been told that, in order to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, **and will be effective for 1 year after the date of my signature, unless specified below.** I also understand that I may revoke this authorization except to the extent that action has already been taken. Refusal to disclose all or some health care information may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. Your signature or refusal to sign this consent will not solely be used as a basis to deny treatment.

This consent shall be in effect from _____ until _____
(not to exceed 1 year-Maine Residential- not to exceed 6 months)

DO YOU WANT TO REVIEW THE INFORMATION BEFORE IT IS RELEASED? _____ YES _____ NO

Signature of Client (age of legal consent)
(Parent, Legal Guardian, Client Representative
if Client is under age of consent)

Authority/Relationship to client

Date of Signature

Signature of Parent, Legal Guardian, Client Representative

Authority/Relationship to client

Date of Signature

If more than one parent/guardian signature is required:

Signature of Parent, Legal Guardian, Client Representative

Authority/Relationship to client

Date of Signature

Signature of Witness

Date of Signature

I have received a copy of this authorization.

I have declined a copy.

(For Office Use Only): MR#: _____ PA#: _____
 Authorization to revoke by: _____
 If revocation of this authorization received:
 Associate member signature: _____
 Associate printed name: _____ Date received _____

Client Name: _____

MR#: _____

Oral Consent (Not applicable to HIV-related information)

***For Persons Physically Unable to Provide a Signature – THIS IS NOT TO BE USED FOR VERBAL
CONSENT OVER THE TELEPHONE.***

I witnessed that the person understood the nature of this release and freely gave his/her oral consent.
(Two witnesses are required.)

Signature of Witness/Date

Signature of Witness/Date

Medical Records
National Headquarters
4085 Independence Dr
Schnecksville, PA 18078

610-799-8822
610-799-8820 Fax

800-25-PEACE

www.kidspeace.org



A Requestor's Directions for completing KidsPeace Release of Information Form

Please ensure the following items are completed:

- Client's Name
- Client's Date of Birth
- Name, address, telephone number of individual and/or Company the documents requested will be going to.
- Purpose – please provide the reason for the request of documents
- "Information to be **RELEASED** is:" – please check ALL documents which are being requested to be released.

NOTE: Checking Other and stating "all medical records" is not acceptable.

- Effected to and from dates, please put in DD/MM/YYYY format. The effective date is to be no more than 12 months.
- Check "yes" or "no" if the individual signing to release the documentation wishes to review the documentation prior to KidsPeace forwards the documentation.
 - If yes, a separate Release of Information Form would need to be completed to release the information to yourself.
 - Please note there would be a charge per page.
- Client over the age of 14 would needs to sign and date the form.
- Client under the age of 14 the parent or legal guardian needs to sign and date the form.
- A witness signature and date on the form.

**ALL OF THESE ITEMS ABOVE ARE REQUIRED BEFORE
WE ARE ABLE TO PROCESS THE RELEASE OF INFORMATION REQUEST.**

Note:

KidsPeace may charge for copies of records in some instances. Our charges are as follows:

\$ 1.42	Amount charged per page for pages 1-20
\$ 1.05	Amount charged per page for pages 21-60
\$ 0.34	Amount charged per page for pages 61-end
\$ 2.05	Amount charged per page for microfilm copies
\$26.70	Flat fee for Social Security/ Disability

Payment is not required with the completed authorization. An invoice will be included with the requested records containing information on where to mail your payment.

