KidsPeace®

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.)

Identifying Information

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

MR/CLIENT #: _____ Admission Date: _____

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
( ) Other (specify) _____

***Client initials required to release substance-abuse related documents.**

☐ 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
( ) Other (specify) _____

***Client initials required to release substance-abuse related documents.**

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/CLIENT #: _____
Authorization to revoke by: _____
If revocation of this authorization received:
Associate member signature: _____
Associate printed name: _____ Date received _____

© Copyright -KidsPeace
1027

Client Name: _____ MR/CLIENT #: _____

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

© Copyright -KidsPeace