Helping children, adolescents and families realize their potential

AUTHORIZATION TO USE/DISCLOSE HEALTH CARE INFORMATION

Completion of this document authorizes the disclosure of individually identifiable health information, as set forth below, consistent with California and Federal Law concerning the privacy of such information.

Client Name: ____________________________________ Birth date: _______________

Parent/Guardian name ((if client is under 18): _______________________________________

I request and authorize (Summit Center professional) ____________________________________
to release and/or obtain the health care information described below to:

Name: ____________________________________ phone number: _____________________

Please initial to specifically authorize the use and/or disclosure of:

____Emergency Room/Urgent Care Records ____Admission Note
____Hospital Records (nursing and progress notes ____Discharge Summary
____Initial Psychological Evaluation ____Clinical Summary
____Medication History ____Psychological Test Report
____Billing Statements ____Verbal Discussion of Case
____Consultation Report (specify): ____

The requested records or information is about health care provided during the following approximate time frame:
____

Authorization expires: _____________________

I understand that I may rescind this consent at any time through written request stating that I do not give permission for further release or disclosure of information.

Date: ________________ **Client/Authorized Representative** ____________________________________
(Signature)

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