Children's
Neuropsychological
Services, LLC

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AUTHORIZATION TO RELEASE AND/OR OBTAIN MEDICAL INFORMATION
FROM PEDIATRICIAN/THERAPIST OR OTHER NAMED INDIIVIDUAL

***IMPORTANT:** YOU MUST FILL OUT A SEPARATE FORM FOR EACH PERSON YOU WISH YOUR CNS CLINICIAN TO OBTAIN OR RELEASE INFORMATION.

PATIENT INFORMATION

NAME OF PERSON BEING EVALUATED: _____

BIRTH DATE OF PERSON BEING EVALUATED: _____

RELEASE OF INFORMATION

Children's Neuropsychological Services, LLC has my permission to release information contained in the record of the patient to:

Name of Pediatrician/Therapist/Other: _____

Name of their place of work: _____

Information to be released: *Any and all information*

Restrictions and/or exclusions (if any): _____

Purpose of Release: *For treatment purposes*

OBTAINING INFORMATION

Children's Neuropsychological Services, LLC has my permission to obtain information regarding the patient from:

Name of Pediatrician/Therapist/Other: _____

Name of their place of work: _____

Information to be obtained: *Any and all information*

Restrictions and/or exclusions (if any): _____

Purpose of Obtaining: *For treatment purposes*

I hereby authorize Children's Neuropsychological Services, LLC (CNS) to release and/or obtain any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that CNS cannot control how the recipient uses or shares released information and that laws protecting it confidentiality at CNS may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. The authorization will expire 365 days from the signature date.

_____ _____ _____

Parent's/Guardian's Signature Parent/Guardian Name Printed Date