Healthy Foster Care America

CONSENT TO OBTAIN CONFIDENTIAL RECORDS OR INFORMATION

Medical Record No. or Stamp

TO: Custodian of records

_____

_____

_____

_____

FROM:

_____
Full Name of Practice

_____
Contact Person

_____
Address

_____

_____ _____
Phone Fax

RE: _____ _____
Patient's Name DOB

_____
Address

For the purpose of continuity of care of the above-named patient, I _____, the above-named patient or guardian of the above-named patient, hereby grant the above designated custodian of records permission to release the items checked below to

_____ name of practice _____

- ❑ Psychological evaluation
- ❑ Social history/guidance counseling records
- ❑ IEP/IFSP/504 plan/education records
- ❑ Academic/EOG test results/academic placement
- ❑ Attendance/behavior/grade reports
- ❑ Classroom observations/teacher comments
- ❑ Behavior scale(s) _____
- ❑ Cumulative health record (including medical reports)
- ❑ Communication necessary to coordinate ongoing care
- ❑ Medical/psychosocial history
- ❑ Immunization record
- ❑ Laboratory reports
- ❑ Mental health/substance abuse evaluation
- ❑ Medications
- ❑ Care plan
- ❑ Treatment summary
- ❑ Discharge summary
- ❑ Other: _____

I understand that this consent allows release of the designated records for the following period:

- ❑ Until one year from today's date
- ❑ Through the current school year
- ❑ Other (*specify*): _____

I also understand I may revoke this consent in writing at any time, but that such revocation becomes effective only when received by the above-designated custodian of records and that disclosure made before such revocation is received is not affected.

_____ name of practice _____ clinical and administrative staff maintains patient confidentiality in strict compliance with state and federal laws. These practices are supported by policies and procedures. These procedures are reviewed and, if necessary, revised on a regular basis. We will ensure that HIPAA regulations on re-disclosure are followed.

Refusal to sign this request will not in any way interfere with the patient's ability to access treatment at this facility.

Signature: _____ Date signed: _____
Patient or Parent/Guardian

Printed name: _____ Witness: _____