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 Perso         | n  |  |
| 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   |                       |  |  |
|  |                       |  |  |
| Psychological evaluation   |                       | Medical/psychosocial history             |  |
| Social history/guidance counseling records   |                       | Immunization record                      |  |
| □ IEP/IFSP/504 plan/education records  |                       | Laboratory reports                       |  |
| Academic/EOG test results/academic placement   |                       | Mental health/substance abuse evaluation |  |
| Attendance/behavior/grade reports  |                       |  |  |
| Classroom observations/teacher comments  |                       | Care plan                                |  |
| <ul> <li>Behavior scale(s)</li> <li>Cumulative health record (including medical reports)</li> </ul>  |                       | Treatment summary                        |  |
|  |                       | Discharge summary                        |  |
| Communication necessary to coordinate ongo   | oing care             | □ 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 ( <i>specify</i> ):  |                       |  |  |
| 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.  |                       |  |  |
|  |                       | ice 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:                             |  |
| Signature: Patient or Parent/Guardian  |                       |  |  |
| Printed name:  |                       | Witness:                                 |  |
| www.aap.org/fostercare   |                       | American Academy of Pediatrics           |  |

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