AUTHORIZATION FOR RELEASE OF INFORMATION RELATED TO MY CHILD'S AD/HD DIAGNOSIS

Child: _____
D.O.B.: _____
Parent Name: _____
Teacher Name: _____
Physician Name: _____

As the parent/guardian of the above named child, I hereby authorize the exchange of educational, diagnostic and treatment information between my child's physician and teacher(s), school support staff, hospital and/or community based specialists who are currently or may become involved with the management of his/her ADHD and associated psychiatric, psychological, and medical conditions. Information will be shared and disclosed by your child's physician(s), teacher(s), and specialist(s) to coordinate clinical care.

This authorization will be valid for a period of twelve (12) months but may be revoked at any time by contacting the above named physician or school with either a written or verbal request. However, until the physician or school receives notice of revocation, they may continue to rely on this Authorization. The above named physician will not deny or compromise treatment; or the payment, enrollment, or eligibility for benefits on the basis of the parent's/guardian's decision to revoke this authorization. Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected under HIPAA.

_____

Parent Print Name

_____ _____

Parent Signature Date