Authorization for Release of Information - Adolescent

I, _____, as legal guardian of _____
Parent/Guardian's Name *Child's Name*

_____, with my signature below, give authorization for Amy Gray, LICSW, to
Child's Date of Birth

release and receive the specific health information described below with:

Name of Person or Agency: _____

Address: _____

_____

Telephone: _____ Fax: _____

Information discussed is to be limited to:
[ ] Confirmation of Services
[ ] Diagnosis [ ] Discharge/Treatment Summary
[ ] Other _____

The information is to be disclosed for the purpose of:
[ ] Evaluation or Diagnosis
[ ] Continuity of Care / Coordination of Services
[ ] Other_____

The parent/guardian may revoke this authorization in writing at any time. To revoke this authorization, send a written statement to Amy Gray, LICSW at the address listed below.

I hereby authorize the following:
_____ (initial) Release of my records via FAX machine. I accept the risk of misdirected information via misdialed phone number and misdirected release within the receiving facility/company.

This authorization shall expire one year from the date signed.

Parent/Guardian Signature: _____ Date: _____

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