Release of Information

4KidHelp, Inc. - And Adults Too
4368 Dressler Rd NW, Canton, OH 44718
Phone: (330) 433-1300 Fax (330) 494-0828 email: info@4KidHelp.com

Patient _____ **Birthdate** _____

I hereby authorize 4KidHelp Inc., to use the following protected health information and/or disclose the following protected health information to the following person(s) and representatives of their organizations:

Agency/Representative to be Contacted for Information

Person _____ Phone _____

Role _____ Fax _____

Address _____

Information Requested

(if no details are specified, provide all records for that item)

- ☐ Medical Records related to _____
- ☐ Assessments for _____
- ☐ Laboratory tests including _____
- ☐ Other medical tests including _____
- ☐ Cognitive & emotional tests including _____
- ☐ Other (specify) _____
- ☐ Legal records _____
- ☐ School records including any ETRs and IEPs
- ☐ Sharing of information
- ☐ HIV and/or AIDS related diagnosed and treatment
- ☐ Alcohol or drug abuse assessment and/or treatment

Limitations

Duration of consent to release information: Consent will last throughout the length of treatment plus 30 days unless stated below:	Other limits: Communication will be back and forth with no limitations unless designated below. Any modification of this consent should be stated below:

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Office Manager, at 4368 Dressler Rd NW, Canton, OH 44718. I understand that a revocation is not effective to the extent that 4KidHelp, Inc. has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

4KidHelp, Inc. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to: 1) Inspect or copy the protected health information to be used or disclosed as permitted under federal law or state law and 2) Refuse to sign this authorization.

Print Here ↙ _____
Print name of person signing form

Print Here ↙ _____
Relationship to patient

Sign Here ↙ _____
Signature

Date Here ↙ _____
Date