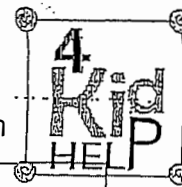


# Release of Information

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)

- |  |  |
|--|--|
| <input type="checkbox"/> Medical Records related to _____            | <input type="checkbox"/> Legal records _____                               |
| <input type="checkbox"/> Assessments for _____                       | <input type="checkbox"/> School records including any EFRs and IEPs        |
| <input type="checkbox"/> Laboratory tests including _____            | <input type="checkbox"/> Sharing of information                            |
| <input type="checkbox"/> Other medical tests including _____         | <input type="checkbox"/> HIV and/or AIDS related diagnosed and treatment   |
| <input type="checkbox"/> Cognitive & emotional tests including _____ | <input type="checkbox"/> Alcohol or drug abuse assessment and/or treatment |
| <input type="checkbox"/> Other (specify) _____                       |  |

### 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



Signature

Print Here



Relationship to patient

Date Here



Date