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Authorization for Release/Exchange of Clinical Information

I, _____, authorize the staff of Advocare Summit Pediatric Associates to exchange clinical information and/or records with:

Mental Health Professionals(and): _____

_____

_____

Regarding my child/children:

Patient Name: _____ Date of Birth: ____ / _____ / _____

Patient Name: _____ Date of Birth: ____ / _____ / _____

Address:

_____

_____

For the purpose of providing comprehensive medical and mental health care coordination.

I understand that the following records/information will be forwarded or communicated and that it will be considered privileged and confidential.

I understand that I have the statutory right not to disclose this information because communications with a psychologist are confidential according to section 28 of P.L. 1966, c282 (C.45:14B-28). I understand that this consent will remain in force for a period of one year from the date of consent.

Parent or Guardian Signature: _____ Date: ____ / _____ / _____

Signature of minor if age 14 or older: _____ Date: ____ / _____ / _____