CENTER FOR PEDIATRIC EXCELLENCE™

CONSENT FOR RELEASE OF INFORMATION

I, _____ give permission for:
(parent/guardian – please print)

Please initial:

_____ A. School _____

Address & Phone number _____

_____

_____ B. Community Agency _____

_____ C. Hospital _____

_____ D. Other _____

_____

To share written or verbal information with the Center for Pediatric Excellence regarding:

_____
(patient name)

I understand that:

a) I may revoke my consent at any time.
b) Information gathered will be treated confidentially.
c) Information will be used for purposes of planning for and providing services for my child and family

Information will not be released to any other third party without my permission unless:

a) I or my child have indicated that there is a risk of harm occurring to me or my family or other person, or there is a disclosure of harm done to me, my family or another.
b) My file is subpoenaed or subject to review by legislation.

Signature _____ Relationship to Patient _____ Date: _____

Patient Signature (16+): _____ Date _____

Witness_____ Date _____