Pediatric & Family Behavioral Health, PLLC
Child, Adolescent and Adult Psychiatry and Counseling Practice
10420 Park Road, Suite 300
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PERMISSION TO OBTAIN/RELEASE RECORDS

I, _____, _____, give my permission for
(patient name) (patient's DOB)

Pediatric & Family Behavioral Health, PLLC to ☐ release ☐ obtain my medical records to/from

_____ so they can better understand my condition
(doctor/hospital/clinic/individual)

Tel.: Fax.:

PERMISSION TO OBTAIN/RELEASE SENSITIVE INFORMATION:

By putting my initials by each item below, I understand that I give permission for records to be sent/obtained that may contain information about:

_____ my mental health,
_____ any transmittable diseases I may have (such as HIV/AIDS, Tuberculosis, or MRSA)
_____ genetic records, and/or
_____ drug and alcohol records.

I UNDERSTAND THAT:

I do not have to give my permission to share these records.

If I want to revoke this permission, I need to talk to my doctor or a staff person and provide written documentation of my decision

This form is only good for the time client is being treated with Pediatric and Family Behavioral Health clinician.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____
