RENNICKE & ASSOCIATES

RELEASE OF INFORMATION FOR MINORS

Name of My Child (Patient): _____ **Date of Birth:** __/___/____

My Name: _____

Relationship to Child: _____

On behalf of the patient, for whom I am a legal guardian of, I authorize **RENNICKE & ASSOCIATES,** whose office is located at the address at the bottom of this page, to disclose and/or obtain treatment information from the following physician, psychiatrist, teacher, or any other person I choose to name below:

Contact Person's Name: _____

Address: _____

Phone: _____ **E-mail:** _____

*If you agree to the **release of all** of this patient's Protected Health Information (PHI), then check the first option below:*

_____ All Protected Health Information (PHI) (e.g., Patient's complete psychiatric record)

*If you want **to limit** what information is released, then choose and check off the option(s) that you agree to below:*

____Mental Health Diagnosis
____Progress Notes
____Treatment Plan
____Medication Records
____Discharge Summary
____Neuropsychological Assessment or Academic Testing Results
____Substance Abuse Information

By signing below I acknowledge that the above information about the patient in my legal guardianship may be released, discussed, or disclosed. I understand that their records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to the office of Courtney Rennicke, Ph.D. *Unless otherwise revoked*, this consent **expires in 12 months** from the date signed. I understand that once information is disclosed as per my authorization, the recipient, in accordance with applicable laws and regulations, may redisclose the information and it might not be protected by federal or state privacy regulations.

Signature of Legal Guardian/Parent: _____

Signature of Witness: _____

Date Signed: _____

Printed Name of Witness: _____