the kids clinic
behavioral health pllc

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

To be completed by parent for patients under the age of 13

Patient's Name: _____ Date of Birth: _____

I request and authorize Katherine Lo, ARNP of The Kids Clinic Behavioral Health PLLC to release healthcare information of the patient named above to:

Name: _____

Method of Contact (phone or fax number): _____

This request and authorization apply to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Verbal exchange of healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of my Sexually Transmitted Infection (STI) results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or addiction treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER IT IS SIGNED.

Katherine Lo, ARNP
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