

Medically Complex Care Consultation Program

Authorization to Release and Request Confidential Information

Child Name: _____

DOB: _____

The Medically Complex Care Consultation Program is authorized to Release and/or Request from:

Individual/Organization	Phone	Email	Address	Consent Date

Individual/Organization	Phone	Email	Address	Consent Date

Individual/Organization	Phone	Email	Address	Consent Date

Person/Program Requesting:

Verbal/Telephone Communication Written Documentation from Child's record

Other: _____

For the Purpose of:

Intake Treatment Planning Transition/Discharge Planning

Other: _____

By signing this consent, I agree to allow the Medically Complex Care Consultation Program to release and/or request information about my child to/from the individual(s)/organization(s) listed for the purpose noted above. I have had a chance to ask questions and get answers about the consent. Unless I withdraw my consent, this consent will remain valid for one year. If I do withdraw my consent, I understand that information about my child that has already been shared cannot be returned.

Consent:

I have reviewed the consent and agree to allow for the communication.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____