AUTHORIZATION FOR RELEASE OF INFORMATION

I. **Information about the Disclosure**

I hereby authorize the use or disclosure of my individual identifiable private healthcare information as described below. *I do understand that this authorization is voluntary and that I may revoke this authorization at any time by submitting my withdraw in writing. I have had ample opportunity to ask questions regarding this authorization, and have had my questions answered to my satisfaction.*

Name: _____

Child name: _____

Persons/Organizations authorized to PROVIDE the information: Reinald Revilla, PMHNP

_____

Persons/Organizations authorized to RECEIVE the information: Reinald Revilla,PMHNP

_____

Specific description of the information that may be released or disclosed:

Pertinent information

_____

Specific purpose of the disclosure: To collaborate on patient care

_____

_____

Limitation of the disclosure: None

This authorization will expire on:

_____/_____/_____

(Please indicate the date or this Release Authorization will stay in place for 1-year)

II. **Information about Your Rights**

I have read and understood the following statements. I have had ample opportunity to ask questions regarding these rights, and have had my questions answered to my satisfactions.

- I may revoke this authorization at any time prior to the expiration date on this document by providing a statement of withdraw to the organization in writing.
- If I revoke this authorization it will not have any affect on the actions that were taken before the revocation.
- I will receive a copy of this authorization.

III. **Signature of Parent or Caregiver:**

_____

Signautre of parent/caregiver Date

_____

Printed name

Relationship to child: _____