AUTHORIZATION TO RELEASE INFORMATION

(THIS AUTHORIZATION IS HIPAA COMPLIANT)

Printed Name of Patient: **Date of Birth:**

I authorize the release of information including diagnosis, records, examination rendered to me, and claims information. This information may be released to and from the staff and clinicians of Stepping Stone Kids Therapy and may be exchanged between Stepping Stone Kids Therapy and the following person(s)/agencies/entities:

Person/Organization to Receive Information:

Street Address:

City: **State:** **Zip Code:**

Phone Number: **Fax/Email:**

This release of information will remain in effect until terminated by patient or guardian in writing.

Printed Name of Parent/Guardian:

Relationship to Patient:

Signature of Parent/Guardian:

Please email completed form along with a copy of your Identification to records@sskidstherapy.com