LISA K. SCHKLOVEN, LCSW-C

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RELEASE OF PROFESSIONAL INFORMATION REGARDING A MINOR CHILD

On behalf of _____ (Date Of Birth: ____/____/_____)

for whom I am the _____ parent _____ legal guardian, I, _____, authorize:

(PLEASE CHECK ONLY ONE CHOICE FROM ABOVE)

_____ INITIALS Lisa K. Schkloven, LCSW-C to release protected health information on the above named child to the individual and/or organization listed below.

_____ INITIALS the individual and/or organization listed below to release protected health information on the above named child to Lisa K. Schkloven, LCSW-C.

Individual/Organization: _____

Address/City/State/Zip: _____

Phone: _____ FAX:_____

Information Authorized for Release in _____ Written and/or by _____ Verbal Format:

_____ Assessment and History	_____ Diagnosis	_____ Treatment Plans
_____ Medical Information	_____ Psychiatric Information	_____ Educational Information
_____ Alcohol/Substance Abuse Information	_____ Family History/Information	_____ Hospital Records/Information
_____ Medical Discharge Summaries	_____ Psychiatric Discharge Summaries	_____ Other (specify) *See Below*

_____

The information will be used or disclosed for the following purposes:
(*Describe the purpose for this use or disclosure of the protected health information or indicate "at the request of the individual.)*

To coordinate treatment protocols to support the above-named child.

PLEASE READ EACH OF THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING THIS DOCUMENT

1. I understand that this authorization will expire one year from the date signed unless a shorter time frame is requested or specified event has occurred.

   *Date to expire (cannot exceed one year from date signed):*_____

   *After specific event has occurred:*_____

2. I understand that this authorization is voluntary and being made at my request.

3. I understand that the released information may no longer be protected by federal privacy laws and may be re-disclosed by the individual or organization that receives it unless this information is protected under Federal confidentiality rules 42 CFR Part 2.

4. I understand that I have the right to refuse to sign this authorization.

5. I understand that I may revoke this authorization at any time by sending written notification to Lisa K. Schkloven, LCSW-C at the address listed at the top of this form. Once received, this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that has already been disclosed, relying on this authorization.

6. I understand that use and/or disclosure or protected health information to a party other than the one designated above is forbidden without additional written authorization on my part.

7. Lisa K. Schkloven, LCSWC is released and discharged of any liability and I will hold her harmless for complying with this Release of Professional Information.

8. By signing this form I revoke any previous *Release of Professional Information* form signed by me at an earlier date.

Signature: _____ **Date:** _____

If the person signing this form is not the parent or guardian of a dependent child under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the child (i.e. Power of Attorney, Court Assigned Guardian, Personal Representative, etc…)