
**Children are not things to be molded BUT PEOPLE TO BE UNFOLDED**

## AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

I am completing this form to allow the use and sharing or protected heath information about:

**Patient Name: _____ Date of Birth: _____**

I authorize disclosure of my child's protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below:

**Please release information to:**

**EFFECTIVE INTERVENTION SERVICES**

4401 Bender Court
Burtonsville, MD 20866
301-531-4267

From: _____

_____

_____

_____

**I want information released from:**

**EFFECTIVE INTERVENTION SERVICES**

4401 Bender Court
Burtonsville, MD 20866
301- 531-4267

To: _____

_____

_____

_____

**I Authorize Effective Intervention Services to disclose the following information:**

☐ All the below
☐ Evaluation Report
☐ Treatment session notes
☐ Billing records
☐ Complete copy of the medical record
☐ Other: _____

_____

_____

*I understand and agree that this authorization will be valid and in effect until December 31, 2019. I understand that after that date, no more of this information can be used or released by Effective Intervention Services, unless I sign a new authorization form. I can revoke consent at any time, provided that the revocation is in writing.*

**Signature: _____ Date: _____**

**Relationship to the patient: _____**