Release of Confidential Information

To:

Re:

Date of Birth:

This is to authorize any physician, hospital, social services agency, clinic, school or others to furnish and release to ProKids or any representative thereof, any and all confidential information, opinions or records which they may request, except __________ _________________________________ and to allow the ProKids representative to examine and/or copy the requested information, opinion, or records for the purpose of preparing a report for the Hamilton County Juvenile Court. I hereby waive any privilege I have to said information to ProKids. I further agree and state that a copy of this authorization shall be considered the original. This release may be revoked by me at any time.

Specific information to be released: ____

____

Please check one:

____ I authorize any information obtained by use of this form or otherwise to be communicated to _______________________

____.

____ I do not authorize any information obtained by use of this form or otherwise to be communicated to _________________

____.

Treatment period (if known): ____.

This release shall expire in (check one): ____ sixty days ____ ninety days ____ six months from the date it has been signed.

Signed: ____

Address: ______________________________________

____

Date: ____

Telephone: ____________________________________

Updated 2.25.2020