Touchstone
Neurodevelopmental Center, LLC

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RELEASE OF INFORMATION

Patient name: _____Date of birth: _____

Parent/legal guardian name (if patient <18): _____

I authorize **Touchstone Neurodevelopmental Center, LLC** to disclose and/or obtain treatment information from the following physician, psychiatrist, hospital, teacher, other treatment provider or organization, relative, or any other person I choose to name below:

Name: _____

Address: _____

Phone:_____ **Fax: _____**

If you agree to the release of all your Protected Health Information (PHI), then check the first option. If you want to limit what information is released, then choose and check off the option(s) that you agree to.

_____ All Protected Health Information (PHI), (e.g., My or my child's complete medical and psychiatric record)
OR (Check all that apply):
____Mental Health Diagnosis
____Progress Notes
____Verbal exchange of information about treatment goals, progress and planning
____Treatment Plan
____Medication Records
____Discharge Summary
____Neuropsychological Assessment or Academic Testing Results
____Eating Disorder Information (Including Assessment & Treatment Records)
____Substance Abuse Information (Including Assessment & Treatment Records)

By signing below I acknowledge that the above information may be released, discussed, or disclosed. I understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to the office of Touchstone Neurodevelopmental Center, LLC. *Unless otherwise revoked*, this consent **expires in 12 months** from the date signed. I understand that once information is disclosed as per my authorization, the recipient, in accordance with applicable laws and regulations, may re-disclose the information and it might not be protected by federal or state privacy regulations.

Patient's Signature: _____ **Parent's Signature (under 18 years) _____**
Date Signed: _____