



Clinic for Special Children

Karen H. Harum, MD FAAP
Neurodevelopmental Pediatrics

Date _____

Authorization for Disclosure of Health Information

I hereby authorize:

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.....

To share with/receive records from:

Clinic for Special Children
6317 Oleander Drive
Suite A
Wilmington, NC 28403
910-251-5150 · 910-251-5159 (fax)

Patient: DOB:

Address:

Phone:

Medical record release dates covering: (from)..... (to).....

Parent/Guardian understands that by signing this document that they are enabling the providers listed above to discuss, exchange, and disclose information pertaining to their child's treatment. Parent/Guardian understands that this will include information relating to (check if applicable):

- Medical care and treatment**
- Education/academic planning and service records**
- Behavioral health service/psychiatric care**
- Treatment for alcohol and/or drug abuse**
- Developmental history/evaluation and treatment**
- Other**

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following day, even or condition one year from date signed. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

.....
Parent/Guardian signature

.....
Date

.....
Relationship to patient

.....
Witness signature

.....
Date

6317 Oleander Drive · Suite A · Wilmington, NC 28403 Phone: (910) 251-5150 Fax: (910) 251-5159