Clinic for Special Children
432 Eastwood Road, Ste 200
Wilmington, North Carolina, US - 28403-1873

Release Form (ROI-1)

Authorization for Disclosure of Health Information

I Hereby Authorize

Provider Name/Practice Name * _____

Phone Number : * _____

Fax Number: * _____

To Share records with:

Clinic For Special Children

P: 910-319- 7744

F: 910-319-7754

Patient's Name * _____

Date of Birth * _____

Address * _____

Phone Number * _____

Medical record release dates covering

(from)____ (to)____ * _____

Parent/ Guardian understands that by signing this document that they are enabling the provider 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 all that apply *

- ☐ 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

I understand this authorization may be revoked in writing at any time, unless otherwise revoked. This authorization will expire one year from the date signed. The facility, its employees, officers and physicians are herby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

PATIENT / PARENT/ GUARDIAN / * _____

Relationship to Patient: Guardian

Date * _____