child &family DEVELOPMENT

PINEVILLE
10516 Park Road, Charlotte, NC 28210
p 704.541.9080 | f 704.542.0699

MIDTOWN
4012 Park Road, #200, Charlotte, NC 28209
p 704.332.4834 | f 704.372.9653

Authorization For Release of Information Form

Client's Name: _____ Date of Birth: _____
(first name last name) (mm/dd/yy)

Printed name of client's representative: _____
Relationship to client: _____

I hereby authorize Child & Family Development to use or disclose individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

INFORMATION AUTHORIZED: (mark or specify) o Designated Record Set
o Other: _____

DATES AUTHORIZED: (mark or specify) o Within last 12 months o Other: _____

PURPOSE OF REQUEST: (mark all that apply) o Exchange and Release Information
o Ongoing Communication o Exchange Information Only o Release Information Only
o Request Information

PERSONS/ ORGANIZATIONS: (complete all fields)

NAME	ADDRESS	PHONE/ FAX #	RELATIONSHIP

ADDITIONAL INFORMATION ABOUT AUTHORIZATIONS

- I understand that this authorization will expire upon the minor's age of majority UNLESS an alternate date of my choice is specified here: _____ (MM/DD/YY)
- I understand that I may revoke this authorization at any time by notifying the providing organization and completing a Revocation of Authorization Form. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorizing the disclosure of this private health information is voluntary and I may refuse to sign this authorization.
- I understand that I may request to inspect or obtain a copy of the information to be used or disclosed.

X _____

Signature of client or client's representative Date