RUDOLPH BOLLING PSYCHIATRY, P.C.

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Birmingham, AL 35209 Fax (844)270-4926

Specific Release of Information

I hereby authorize an exchange of the following protected information of:

Patient Name:_____ D.O.B._____ with

(Phone/ Fax number)

Pediatrician/ Family Practitioner _____
School _____
Pharmacy _____
Counseling Center _____
Foster Care Agency _____
Other _____
Other _____

[ ] Check here if this is an update for one of the above and all other information on the original document remains correct.

PURPOSE OF RELEASE: Coordination of Care_____

SPECIFIC INFORMATION TO BE RELEASED to any of the above could include **ALL** of the following, as appropriate and necessary. **(Things that should NOT be shared are checked below.)**

[ ] IEP Plans [ ] Vanderbilt Evaluations [ ] Psychological and / or Educational Evaluations
[ ] School Attendance Records [ ] Social / Emotional / Academic Functioning at School
[ ] History and Physical [ ] Psychiatric Records [ ] Prior Authorizations
[ ] Outpatient Treatment Notes [ ] Phone Communication between parties
[ ] Other (specify): _____

DATES covered by this authorization are from _____ **until written notification is received from the guardian that this information should change.**

It is my understanding that this information will be used solely for the purpose described above. I understand that the information which I am authorizing to be released may include psychiatric diagnoses and or drug/alcohol related information. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy rule. I understand that I may revoke my permission in writing at any time. Any actions RUDOLPH BOLLING PSYCHIATRY, PC may have taken before receiving notice that the consent has been revoked would not be covered by the revocation. I hereby release RUDOLPH BOLLING PSYCHIATRY, PC and its duly authorized agents from all legal responsibility or liability for the release of information indicated and authorized herein.

A duly signed and completed fax or photocopy of this form is considered valid.

Parent/Guardian Signature: _____ Date: _____
Relation to Patient: [ ] Parent [ ] Legal Guardian [ ] Foster Parent [ ] Other _____

Witness: _____ Date: _____