



CHILD RELEASE OF INFORMATION FORM

I, _____, hereby authorize Dr. Segal to release information pertaining to the diagnosis and treatment of my child to the following provider/individual(s)/entity:

1) _____

2) _____

3) _____

Information to be used for the purpose of:

☐

Treatment Care and Coordination

☐

Other (ex. billing)

I understand that this authorization shall remain valid from the date of my signature below and indefinitely thereafter

(or sooner if specified) ending on:

☐

I have been informed that I may revoke this authorization by written communication with Dr. Segal at any time.

☐

I certify that this form has been fully explained to me and that I understand its contents.

Parent or legal guardian signature

Caring, Compassionate, Comprehensive

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