siskin children's institute
education • outreach • health care • research

center for DEVELOPMENTAL PEDIATRICS
An academic pediatric practice affiliated with the University of Tennessee College of Medicine Chattanooga

AUTHORIZATION TO RELEASE INFORMATION - SCHOOL
(Must complete all fields for document to be processed)

Patient's Name: _____
Patient's Address: _____
City, State, Zip: _____
Date of Birth: _____ Telephone #: _____
Medical Record #: _____

Release of Information from Siskin	**Release of Information to Siskin**
☐ I authorize Siskin to release copies of my records as listed below. The information should be sent to:	☐ I authorize the school listed to release information to:
Name of School _____ Attention: _____ Address _____ City, State, Zip _____ Telephone Number _____ Fax Number _____ *Please note that information disclosed to this authorization may be subject to re-disclosure by the recipient and no longer protected by Siskin.	Please send information requested below to: **Siskin Center for Developmental Pediatrics** 1101 Carter Street Chattanooga, TN 37402 P(423)490-7710 F(423)490-7750

DATES OF TREATMENT (Dates of treatment you need records for)

Dates: _____ school year ____/____

(The information that is to be released should be detailed to specific dates of service, treatment, etc.)

Information to be Released			
_____	Diagnosis and Treatment Plan	_____	School Records
_____	Psychological Testing	_____	IEP
_____	Occ Therapy Records	_____	Other (list)
_____	Phys Therapy Records		
_____	Speech Therapy Records		
_____	Medication Information		

Authorization for Verbal Communication

I authorize verbal communication to occur between SCDP and the above listed school as it pertains to the care and educational needs of my child (listed above.)

Parent/Legal Guardian Initials _____

If you **DO NOT WANT** certain portions of your medical records released, please initial for the information you do not want released: _____Substance Abuse _____Psychological or Psychiatric Treatment____HIV/AIDS/STD

I understand I have the right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure which may not be protected by federal confidentiality rules. I undertand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization. I understand that treatment, payment, enrollment, or elligibility for benefits may not be a condition to obtain this authorization.

This authorization is for school year ___/___ or expires: _____ (date).

Note: This form will automatically expire 365 days from signature date below.

_____ _____ _____
Signature of patient, parent or legal guardian Print Name Date

Relationship if not patient: _____