Christine LaComb
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Authorization to Obtain and / or Release Confidential Information

Patient Name _____ DOB: _____

The records requested include (check as appropriate):

- ☐ Medical (inc. consultations, PE's etc.)
- ☐ Psychiatric (evaluations, treatment)
- ☐ Psychological testing reports
- ☐ School records
- ☐ Laboratory studies
- ☐ Other _____

This authorization pertains to information regarding me or my minor child's evaluation and treatment, including medical, psychological, educational, drug, and alcohol, and any other relevant information. I understand it can be revoked any time in writing. A photocopy of this consent is as valid as the original. The purpose of this authorization is to (check appropriate).

- ☐ Facilitate evaluation and treatment
- ☐ Coordinate treatment between providers
- ☐ Other _____

This authorization is effective for a period of (not to exceed one year)

- ☐ One year from the date below
- ☐ Other (specify) _____

I hereby authorize and request (name of person with records) Relations to patient: SELF PARENT GUARDIAN _____ _____ _____ To release confidential information to: Christine LaComb, RN, FNP-C Signature _____ Date _____	I hereby authorize and request Christine LaComb, RN, FNP-C To release confidential information to: (Name of person needing records) _____ _____ _____ Signature _____ Date _____