siskin children's institute

DIAGNOSIS | TREATMENT | SUPPORT

for Children with Special Needs - *Since 1950*

AUTHORIZATION TO RELEASE INFORMATION – General & School Consent

(Must complete all fields for document to be processed)

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ Phone #: _____

City/State/ZIP: _____ Medical Record #: _____

Release Information FROM Siskin	Release of Information TO Siskin
I authorize the below listed Physician (Phy.), Institution (Inst.), or School (Sch.) to release and/or obtain information requested on this form to Siskin Children's Institute. ☐ Release ☐ Obtain **The information should be sent from:** Phy., Inst., or Sch.: _____ Address: _____ City/State/Zip: _____ Phone # _____ Fax #: _____ Please note that the information disclosed to this authorization may be subject to re-disclosure by the recipient and no longer protected by Siskin.	☐ I authorize Siskin Children's Institute to verbally speak to the listed Physician, Institute, or School listed to the left: Please send information requested to: **Siskin Children's Institute** **2201 Murphy Ave., Suite 306, Nashville, TN 37203** **P: (615) 730-8095 F: (615) 730-9135**
	Dates of Treatment (Dates of treatment you need records for) Dates: _____ The information that is to be released should be detailed to specific dates of service, treatment, etc.

Information to be Released		Purpose of Release	
☐Clinic Visits	☐Labs	☐Ongoing Care with SCDP	☐Insurance
☐Psychological Records	☐X-Ray/Img	☐Cont. Care	☐Deposition
☐OT Therapy Records	☐IEP	☐Billing	☐Attorney
☐PT Therapy Records	☐Other: (list)	☐Work Comp	☐Other (list)
☐ST Therapy Records	_____	☐Social Sec.	_____
☐Medication Information	_____	☐Disability	_____

If you DO NOT WANT certain portions of your medical records released, please initial for the information:

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 carrier with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand 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 eligibility 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 in 365 days from signature date below.

Signature of patient, parent, or legal guardian	Print Name/ Relationship to child	Date