CARTERET CHILDREN'S CLINIC

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Authorization for Exchange of Confidential Information

Patient Full Name: ______________________________

Patient Date of Birth: ______________________________

Person, Agency or School

Name: ______________________________

Contact person: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone number/ fax number: ______________________________

I hereby authorize the exchange of confidential information between the above entity and **Carteret Clinic for Adolescents and Children.** The purpose for which information is to be exchanged may include medical and/or educational planning, placement, progress, or referral information. This consent will be in effect for one year from the date of signature and can be revoked at any time by written signature.

I understand this authorization *may* include medical records for treatment of physical and/or emotional and mental illness, including the treatment of alcohol or drug abuse, or drug related conditions. I also understand that HIV, AIDS, or AIDS-related information may be exchanged.

Parent/legal guardian signature: ____________________ DATE: ______________

Please PRINT name: ______________________________

Witness: ______________________________

REVOCATION OF AUTHORIZATION

REVOKED ON (DATE): ______________________________

BY (PRINT NAME): ______________________________

Signature: ______________________________

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