Muriel S. McClellan, Ph.D.

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Consent for Disclosure of Protected Health Information - Child

I hereby authorize Dr. Muriel S. McClellan (x) to release information to:
(x) to receive information from:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Pertaining to my child: Date of Birth

_____ _____

It is my understanding that when this form is completed and signed, it authorizes Dr. McClellan to release and/or receive information to/from the person stated above about your child(ren). This consent to release and/or receive information can include the following:

(x) Treatment Summary	(x) History, Background Information
(x) Treatment Plan	( ) Discharge Summary
(x) Progress Notes	( ) Letters and other correspondence
( ) Diagnosis	( ) Reports
( ) Psychological Testing Results	( ) Other _____

I understand that the intention is to use this information to help with the co-ordination of services Dr. McClellan is providing with the above named person.

I have read the above and fully understand its contents. This consent shall remain in effect for twelve (12) months, but can be revoked in writing at any time, except to the extent that action has already been taken. I understand that after information is disclosed it may not be protected by the federal privacy rule and could possibly be released to someone else. Generally you are not required to sign this consent and if you do not sign this it will not effect your child's treatment, unless it is Court ordered. You can review your specific Court orders for guidance. If this is Court ordered and a report to the Court is required, the information released may be included in a Court record with publc access. All efforts will be extended to handle this in a professional manner. A photo copy of this authorization will serve as valid as the original.

Name of Parent (please print) _____

Signature: _____ Date: _____