C H A D I S

The completed *permission to obtain or release information* form is being shown here for your review and signature. Please sign the bottom by typing-in your name in the "Signature" box.

CONSENT FOR EXCHANGE OF INFORMATION

I hereby authorize

(Agency or Professional) _____
(Address) _____

to exchange information about my child _____Date of Birth _____ with

(Clinician) _____
(Address) _____

Please exchange the following types of information (uncheck any you do not approve):

- _____ questionnaires
- _____ academic records
- _____ medical records
- _____ mental health records
- _____ developmental testing/assessments
- _____ substance use information

I understand that:

- this authorization is aimed at assisting this child's health care.
- this authorization is voluntary.
- this child's treatment will not change if I do not agree to this.
- the only risk is loss of confidentiality. I also understand that the computer system being used to exchange information is secure.
- this child's records are protected as confidential under Federal law.
- I may revoke this consent at any time except to the extent that action has been taken on it (e.g., already communicated).
- this consent automatically expires in one year, if this child is no longer cared for by this doctor or agency.
- that I may print this form and that I may request a copy of the information provided.

Please sign this *permission to obtain or release information* form by typing in your name in the "Signature" box. This constitutes a legal signature when filled out properly and in good faith.

Signature _____

Date: _____