RELEASE OF INFORMATION/
CONSENT FOR COMMUNICATION WITH PRIMARY CARE PHYSICIAN

In an effort to coordinate the care of our patients with their providers in the community, as well as to fulfill insurance obligations, we are requesting your permission to inform your child's primary care physician about your child's participation in an assessment and/or treatment. Speaking with a primary care physician is helpful, concerning issues of medication, treatment follow-up, and psychological issues affecting your child's well-being. Moreover, as your child's primary care physician carries responsibility for your child's medical care, it is important the physician have access to information related to your child's health and treatment.

____________________________________ ____________________________________
Child's Name Date of Birth

PHYSICIAN INFORMATION

____________________________________ ____________________________________
Name of Physician Name of Practice

____________________________________ ____________________________________
Physician's Phone Number Physician's FAX Number

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Physician's Address City, State, and Zip

CONSENT

❑ I, ______________________________, hereby give
Katy Child Psychology Associates, 21384 Provincial Blvd, Katy, TX 77450 Ph:281-829-1599
permission for the mutual exchange of pertinent information with my child's primary care physician, including academic, social, medical, psychological, and/or psychiatric information.

Purpose of disclosure:
❑Continuity of care ❑ Insurance/Reimbursement ❑ Other (specify :____________________)
Information requested:
❑All ❑ Specific items (specify :____________________)

❑ I, ______________________________, hereby decline to give permission for the mutual exchange of pertinent information with my/my child's primary care physician.

I may revoke this authorization in writing at any time. This authorization is valid until I revoke it or 60 days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. This authorization was explained to me and I signed it of my own free will.

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Printed Name of **Child/Patient**

____________________________________ ____________________
Signature of **Parent/Guardian** Date

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Relationship to Child/Patient