THE RETREAT AT PONTE VEDRA BEACH

Release of Informtion

Office Name:		Phone:	
Office Address:		Fax:	

I, _____ (parent/legal guardian), hereby authorize The Retreat at Ponte Vedra Beach (Dr. Burton / Dr. Winings) to have mutual (back and forth) exchange of information that is contained in _____ (child's name) _____/_____/_____ (date of birth) medical record with the following:

1. _____ for the purpose of _____
2. _____ for the purpose of _____
3. _____ for the purpose of _____

This information will be limited to:

____ Psychiatric/medical/alcohol/drug abuse initial evaluation.
____ Psychiatric/medical/alcohol/drug abuse discharge summary.
____ Psychotherapy Notes ____ Progress Notes
____ Psychological testing ____ Educational testing
____ Lab studies ____ Other:
____ Medical tests/studies ____ Other:

____I authorize telephone communication to give / to receive information with the circled providers listed above for the purpose of coordination of care for duration of treatment and 90 days after discontinuation of treatment, closure of medical record.

_____ _____
Signature of Patient Date Signed

This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate 90 days after closure of medical record **or** upon _____.

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Parent, Legal Guardian or Conservator Date Signed

_____ _____
Signature of Witness (if appropriate) Date Signed