Boston Child Study Center

LOS ANGELES

Expert Mental Health Treatment, Training & Research

AUTHORIZATION FOR RELEASE OF INFORMATION

I, __________________________ (Name of Client name or Parent/Legal Guardian of minor under 18), hereby authorize Boston Child Study Center-Los Angeles staff to release information to and request/receive information from:

Provider:	Name/Address:	Phone:
PCP/ Pediatrician	____	(_______)_______________________
Psychiatrist	____	(_______)_______________________
Individual Therapist	____	(_______)_______________________
Family Therapist	____	(_______)_______________________
School	____	(_______)_______________________
Case Manager	____	(_______)_______________________
Other ( )	____	(_______)_______________________
Other ( )	____	(_______)_______________________

Communication may include any and all information in their possession acquired in the course of evaluation and/or treatment of the above named child/adolescent/patient. In addition, I authorize the staff of Boston Child Study Center-Los Angeles to share information with any emergency care givers who are involved in the care of my child in the event of a medical or psychiatric emergency. This authorization is voluntary and I have the right to refuse to sign it. I may revoke this authorization at any time by providing written notice of revocation; however such revocation would not affect any action taken by the Boston Child Study Center-Los Angeles in compliance with this authorization before receipt of my written, hard-copy, revocation. You may accept photocopies or facsimiles of this authorization.

______________________________________   ___________   ____________________________

Signature of Patient or Parent/Guardian of minor   Date   Relationship to Child

11400 West Olympic Boulevard : Suite 200 : Los Angeles, California 90064

www.BostonChildStudyCenterLosAngeles.com

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