Stone Soup Group

Supporting families who care for children with special needs

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www.stonesoupgroup.org

Authorization for Release of Information

Recipient's Name: _____

Record Number or Other ID: _____ Date of Birth: _____

Other names under which record may be filed: _____

Description of information to be released and method ☐ Verbal ☐ Written

_____

_____

The purpose of obtaining/releasing information is to coordinate services for your family member. This information is essential to providing a comprehensive planning process and to recommend appropriate services for your family, as well as to avoid unnecessary services and duplication of efforts.

The following people/organizations have been involved, or will be involved with my family member's care. I authorize the mutual exchange of information between the Stone Soup Group and entity listed below:

Name of Entity:	Phone: _____
	Fax: _____

I hereby authorize the use of disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand that I may revoke this authorization at any time by notifying Stone Soup Group and the individuals/organizations releasing information in writing at any time. I understand that this information will be kept in my family member's file and will not be released without my permission. All practices of confidentiality will be followed in the use of the information gathered. This release is valid for 12 months after the date it is signed. I can choose to revoke this release of information at any time by notifying Stone Soup Group. Signature of a parent or guardian required if the recipient is under 18 years old.

SIGNATURE	RELATIONSHIP	DATE
PLEASE PRINT NAME	Signature of Staff	