Patriot Pediatrics
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Patient's Name: _____ Date of Birth: _____

Release of Confidential Educational/Behavioral Information TO Patriot Pediatrics

I hereby authorize:

Name of Provider: _____

Address: _____

Phone: _____ Fax: _____

To exchange confidential information regarding my treatment to Patriot Pediatrics. This authorization permits the exchange of the following information:

- ☐ Test Results
- ☐ Treatment Plan
- ☐ School Records, IEP, Assessments
- ☐ Diagnosis
- ☐ Progress Reports
- ☐ Any and All Pertinent Information

Signature of Responsible Party: _____

Relationship to Patient: _____ Date: _____

This authorization ends on _____ or 1 year from the date of signature.

Release of Confidential Educational/Behavioral Information FROM Patriot Pediatrics

I hereby authorize Patriot Pediatrics to exchange confidential information regarding my treatment to:

Name of Provider: _____

Address: _____

Phone: _____ Fax: _____

This authorization permits the exchange of the following information:

- ☐ Test Results
- ☐ Treatment Plan
- ☐ School Records, IEP, Assessments
- ☐ Diagnosis
- ☐ Progress Reports
- ☐ Any and All Pertinent Information

Signature of Responsible Party: _____

Relationship to Patient: _____ Date: _____

This authorization ends on _____ or 1 year from the date of signature.