Avon Pediatrics 7376 Business Center Dr., Suite A,

Avon, IN 46123, Ph# 317-272-7887 Fax# 317-272-7888

Two-way Release of Information

Patient/ Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we release information to – List name, specialty, phone number, fax number, email:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, as this child’s parent or guardian, give permission for the following records and/or information to be shared between parties’s listed and the child’s healthcare provider. I agree that this release will be in effect for one year from today’s date, and will include information communicated by phone, fax, email, and U.S. mail.

Please check all records/information that may be shared:

Psychological Evaluation Audiology Evaluations

Speech, Hearing, Language Evaluation & Physical Therapy, Occupational Therapy Evaluation

Therapy

Case Conference Report Ophthalmology Evaluations

Transcripts & School Records Counseling Information

Individual Education Program Optometric Evaluation

Individual Health Plan Probation Information

Medical Information Other:

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Parent/Guardian Signature Today’s Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent/Guardian