Pediatric Feeding Institute

South Florida

AUTHORIZATION TO RELEASE INFORMATION TO OR FROM PEDIATRIC FEEDING INSTITUTE OF SOUTH FLORIDA

Name of Child: ____

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information for payments or administrative purposes as it relates to treatment.

I understand that I have the right to know at all times what information is shared regarding myself or my child. I understand that the identity of the designated parties must be verified before the release of my information. I know that I have the right to revoke this authorization at any time in writing.

Name of Physician: ____

Purpose: ____

Type of information released: ____

(This information is required to send the evaluation to the physician and authorize treatment for insurance purposes)

Name of Teacher: ____

Purpose: ____

Type of information released: ____

(This information is required if you would like us to have contact with your child's teacher before, during, and/or after the program)

Name: ____

Relationship: ____

Purpose: ____

Type of Information Released: ____

Parent Signature: ____

Print Parent Name: ____

Date: ________________________________