Children in Motion
10587 Double R Blvd #101
Reno, NV 89512

Authorization for Release of Information or Individual Access to Information

I hereby authorize/request _____ to release/or grant me access to the patient information of:

_____ _____
Patient's Full Name Date of Birth

I request ONLY the following information to be released/accessed:

❑ Evaluation Reports ❑ Progress Notes ❑ Discharge Summary ❑ Phone Conference ❑ Email Contact	❑ Emailing of Reports ❑ Insurance Correspondence ❑ Other (specify): _____

Release or Mail to: _____
_____
_____

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and /or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither health care provider nor any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do so.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire one hundred eighty (180) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax, or bring the letter to the address or fax number noted at the top of this page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as a legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate if the patient did not expire in the facility the information is requested from.

NOTE: Records will be mailed to above address unless otherwise noted.

_____ _____
Signature of Patient/Legal Guardian/Personal Representative Date

_____ _____
If someone else signs on behalf of patient, state your relationship to the patient. Date