Release of Information

ADHD in children is often best treated with a team-based approach, where there is frequent cooperation and communication between the child's school, parents, and health care providers.

By law, every individual's medical records are confidential. However, there are times when information-sharing can be useful when treating ADHD. A Release of Information form grants authority to your child's health care providers to share certain health information with your child's school. This could include information about your child's ADHD diagnosis or medications. The sharing of this information can be very useful when coordinating a team-based approach.

WHO SHOULD USE THIS TOOL?

The Release of Information form should be completed by the child's parent or guardian.

HOW SHOULD IT BE USED?

The middle portion of this form should list your child's health care provider (for example, a pediatrician or psychiatrist) as well as someone from your child's school. This could include a teacher, nurse, special education coordinator, or other school official. The purpose of this form is to allow the two listed parties to share medical information about your child.

RELEASE OF INFORMATION

THIS FORM CONFIRMS YOUR AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

CONFIRMATION OF AUTHORIZATION
I give my authorization for the people named below to share health information about my child's ADHD evaluation, diagnosis and treatment.

Child's Name: _____

Parent/Guardian's Name: _____

Address: _____

Telephone: _____

USE OF PROTECTED HEALTH INFORMATION
This information is to be used to coordinate services and treatment planning for the child named above, and may include information about my child's medical history, behavior, performance in school, and medications.

Teacher/School Official you are authorizing to receive, use and/or disclose the protected health information described above:

Name: _____

Telephone: _____

Treatment Provider you are authorizing to receive, use and/or disclose the protected health information described above:

Name: _____

Telephone: _____

BY SIGNING BELOW

- I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization.
- I understand that I may revoke this authorization at anytime by giving notice to the parties named above.
- I understand that by signing this form, I am confirming my authorization for release, disclosure and use of my child's protected health information.
- This authorization will expire in 180 days, unless otherwise changed and/or revoked.

_____
Name of Parent/Guardian

_____
Name of Witness

_____
Signature of Parent/Guardian

_____
Signature of Witness

_____
Date

_____
Date