315 Oak St. Suite 200
Hood River, OR 97031
Phone: 541-386-0009
Fax: 541-386-0029

Authorization to Release Protected Health Information

I hereby authorize KIDSENSE, INC. to release and receive protected health information to/from:

_____
Agency/Individual Name

_____
Address

_____
Phone Number

_____
Fax Number

For the purpose of:

Evaluation and treatment planning_____

I authorize release of the following:

_____

_____

I understand that I may revoke this authorization at any time by submitting a written request to the Center. Such a revocation does not apply to releases prior to the date of the request.

Name of child:_____

_____ _____
Client or Legal Guardian **Date**

2009 form