MONTE W. DAVENPORT, PH.D.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I. Child/Teen Name _____ DOB_____

II. Please check and provide the requested information:

_____ I hereby authorize Monte W. Davenport, Ph.D, to disclose Protected Health Information of the above named minor child to the following organization(s) and/or person(s) via mail, phone, fax, or email.

Name _____

Address_____

Phone Number: _____ Fax Number: _____

Email: _____

_____I hereby authorize the above named organization and/or persons to disclose Protected Health information of the above named minor child to Monte W. Davenport, Ph.D.

III. I authorize the following information to be disclosed:
CHECK ONE

_____ Complete Medical Record, including records from other providers.

_____ Information Relating to _____

IV. Purpose of the Requested Disclosure: Please check one and provide the requested information.

_____ At the request of the parent. _____
(parent's initials)

_____Other _____
(state specific purpose of requested disclosure)

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided Monte W. Davenport, Ph.D. and Associates, PLLC. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my minor child's Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Monte W. Davenport, Ph.D. and Associates, PLLC may not condition treatment on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release and a fax or email of this release shall be as valid as this original release. If I authorize Monte W. Davenport, Ph.D. and Associates, PLLC to mail, fax, or email the information requested, I realize there are inherent risks in faxing and emailing Protected Health Information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

This authorization expires upon_____(date)

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

550 Silicon Drive, Suite 100, Southlake, TX 76092
phone: 817.421.8780, fax: 817.421.0049, email: info@drmontedavenport.com