

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
A Child's Dream

Patient Name

Date of Birth

Parent/Legal Guardian Name

Patient SSN

Address

Phone Number

Other names patient has used

HEALTHCARE PROVIDER

ADDRESS

I hereby authorize the listed healthcare providers and its physicians and employees to release or disclose to A Child's Dream and its representatives, employees, and volunteer medical advisors records and information pertaining to treatment, prognosis, and diagnosis including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, HIV infection, cancer, or physical or sexual abuse.

PURPOSE OF DISCLOSURE: This disclosure is solely for the purpose of evaluating a pending application for the granting of a dream. The information will be used to determine the type and scope of a child's illness or abuse. This information will not be shared with any other organizations or individuals not related to the evaluation of a pending application.

I understand that I am not required to sign this authorization. However, I understand that if I do not sign this authorization, the mentioned child may not be considered for the granting of a dream through A Child's Dream.

Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Parent/Legal Guardian Signature

Date

Relationship to Patient
