**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_ , hereby authorize the following agencies/physicians to furnish all

**(Parent/Guardian)**

medical information, at the request of the above, concerning my child to: Joya Child & Family Development.

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| --- | --- | --- |
|  | **AGENCY/CLINIC NAME** | **CITY, STATE (if other than Spokane, WA)** |
| **Where was your child born?:** |  |  |
| **Current Primary Care Provider:** |  |  |
| **Previous Primary Care Provider(s):** |  |  |
| **Hospitals, Urgent Cares, ERs:** |  |  |
| **Previous OT, PT, Speech:** |  |  |

|  |  |  |
| --- | --- | --- |
|  | **AGENCY/CLIINIC NAME** | **CITY, STATE (if other than Spokane, WA)** |
| **ENT/Allergist:** |  |  |
| **Eye (Ophthalmology):** |  |  |
| **Cardiology/Pulmonology:** |  |  |
| **Neurology:** |  |  |
| **Orthopedics:** |  |  |
| **G.I. (Gastroenterology):** |  |  |
| **Genetics:** |  |  |
| **Nutritionist/Registered Dietician:** |  |  |
| **Please use the following rows for any other provider, including: Endocrinologist, Urologist, Hematologist, Lactation Consultant, Maternal Fetal Medicine, General Surgery.** | | |
|  | **AGENCY/CLIINIC NAME** | **CITY, STATE (if other than Spokane, WA)** |
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| **I understand that:** This authorization is voluntary. I do not have to sign this form for the patient to receive services (evaluation, enrollment, or therapy). The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I may inspect and receive a copy of this document. I may revoke this authorization at any time in writing, but the revocation will not apply to information already used or disclosed. ***This authorization is valid for the duration of care.*** |
| **SPECIFIC AUTHORIZATION:** I understand that my express consent is required to release information relating to sexually transmitted diseases, mental illness, psychiatric treatment, and/or drug/alcohol abuse. If my child has been tested, treated, or diagnosed in connection with any sexually transmitted disease, or drug/alcohol abuse, or mental illness or psychiatric treatment, Joya Child & Family Development is specifically authorized to receive all information in medical records relating to such diagnosis, testing, or treatment. This request is a free and voluntary act by me. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature of Parent/Legal Guardian Relationship to Child Date** |