



The Jones Center for Children's Therapy and Assessment

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AUTHORIZATION TO RELEASE TESTING REPORT

This form can only be completed by a patient, parent, or guardian with the legal authority to provide consent for medical treatment.

This signed document authorizes JCCTA to disclose results of testing and related information, including the associated comprehensive report, for: _____, DOB: _____.

Please include on this form all parties who have the legal right to access medical records, including yourself and any other custodial or non-custodial parent(s)/guardian(s). If there is a medical professional to whom you would like a copy of the final report released, such as a psychiatrist or pediatrician, please include that individual's information as well. Please note, JCCTA does not release reports directly to schools.

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

I acknowledge the following:

- I understand I may revoke this authorization at any time by notifying JCCTA in writing.
- I understand, upon request, JCCTA will provide me a copy of this authorization after I sign it.
- I understand I may be asked to show proof I have the authority to sign an authorization to review and/or receive copies of the aforementioned information of the named patient's medical record.
- I agree a facsimile or photocopy of this authorization is as valid as the original.

Date

Printed Name of Patient, Parent, or Legally Authorized Representative

Signature of Patient, Parent, or Legally Authorized Representative

Relationship to Patient

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