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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