Harbor Shelter
& Counseling Center

PARENTAL RELEASE OF CLIENT MEDICAL RECORDS REGARDING PRESCRIBED MEDICATION

Client's Name:_____ Date of Birth: _____

This authorizes (Physician's name and address of medical facility):_____

_____

_____

to release to and/or exchange with Harbor Shelter and Counseling Center pertinent information from my child's medical record regarding prescribed medications. The information is needed for evaluation and treatment planning.

The information to be disclosed includes:

-Instructions on how the prescribed medication is to be administered.
-The symptoms the medication will alleviate.
-The symptoms that would warrant consultation with the physician.

I understand that I may refuse to sign this consent, if I so desire. However, refusal may limit or prevent service from Harbor Shelter.

I understand that I may revoke this consent at any time. I understand, further, that the consent expires upon fulfillment of the above stated purpose(s) or one year after signature date, whichever is first.

Other specifications of the date, event, or conditions upon which this consent expires:

_____

_____

Signature of Responsible Party for Minor: _____

Date: _____

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