

THE CENTER FOR CHILDREN WITH SPECIAL NEEDS
The Floating Hospital for Children
Tufts-New England Medical Center

PATIENT INFORMATION

Child's Name: _____ DOB: _____

Parent Name(s) _____

Street Address: _____

City/Town: _____

Telephone Numbers: Home: () _____ Work: () _____

Insurance/HMO _____ Primary Care Pediatrician : _____

TWO-WAY RELEASE OF INFORMATION

I hereby give permission to the Center for Children with Special Needs of Tufts-New England Medical Center to exchange information and records relative to my or my child's evaluation. This means that the individuals and agencies listed below have my authorization to release their records pertaining to me or my child's evaluation to the CCSN, and also means that the CCSN can release records to the individuals and agencies listed below. This release of information also gives permission for the CCSN and the individuals and agencies listed below to exchange information by telephone.

If my child's school is funding these evaluations, I give permission to send the results of my child's testing to the school system, which has contracted with the CCSN. I understand that if I do not give permission for these records to be released I am financially responsible for payment of the evaluations.

Primary Care Physician:

Name:

Address:

Telephone #:

Referring Physician/Professional (if different from Primary Care Physician):

Name:

Address:

Telephone #:

Date

Signature

Relationship to child

(Continued on page2)

The Authorization allowed by this form is described on Page 1. Exchange of information is authorized for the individuals and agencies listed below:

School system:

Name of Contact Person:

Name of School:

Address:

Telephone #:

Other:

Name:

Address:

Telephone #:

Date

Signature

Relationship to Child

(Continued from page1)

This Release is Valid for One year from Date of Signing