frazier
behavioral health

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____
Parent Name: _____ Phone:_____
Address:_____

I authorize:

Frazier Behavioral Health LLC
841 E. Fayette St.
Syracuse, NY 13210
FBHrecords@quadrarntbiosciences.com

To release my child's protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to: (New Doctor,Parent, School, Daycare, Therapy Center, etc.)

Name: _____
Address:_____
Email: _____
Telephone:_____
Fax:_____

The purpose of this request is to ensure the continuity of medical care.

I authorize the release of the entire medical record (or specify other):_____
_____

I understand that this authorization will expire one (1) year from the date on which it was signed. I understand I may revoke this consent at any time by contacting FBHrecords@quadrantbiosciences.com; however, that will not affect disclosures made in reliance on this Authorization. I understand that my child may receive care even if I do not consent to release their health records.

Parent/Guardian Signature:_____ Date _____

Parent/Guardian Printed Name:_____