MEYER CENTER FOR SPECIAL CHILDREN
1132 RUTHERFORD ROAD
GREENVILLE, SOUTH CAROLINA 29609

AUTHORIZATION FOR REQUEST/RELEASE OF INFORMATION

Child's Name: ______________________________________ **Date of Birth:**___________________

I hereby authorize the Meyer Center for Special Children to receive/release records regarding my child to the following agencies. ***(Please specify names of the agencies with which the Meyer Center may receive and release your child's records. Include: Physicians, Greenwood Genetics, therapy clinics, hospitals, early intervention services, etc.)***

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Records to be received/released are limited to the following:

Clinic/Discharge Notes
Telephone Contact to Insure Coordination of Services
Education (IEP)/Therapy/Psychological Evaluations and Progress Notes
Vision and Hearing Screenings

I hereby give my permission for medical information concerning my child to be received and released by Meyer Center for Special Children. I understand that this authorization is voluntary, and that I may revoke this authorization at any time by notifying the Meyer Center for Special Children in writing, specifying the date of revocation. If I choose to do so, I understand that my revocation will not affect any actions taken by the Center before receiving my revocation.

This authorization will expire on August 17, 2012.

____________________________________ ____________________

Parent/Guardian Signature **Date**