CHILDREN'S DEVELOPMENTAL CENTER OF LIMA, INC.
Lima Memorial Hospital, 1001 Bellefontaine Avenue
Lima, Ohio 45804 (419) 226-5046

AUTHORIZATION FOR RELEASE OF INFORMATION

The Children's Developmental Center of Lima, Inc. is hereby granted my permission to release to/obtain from_____

_____

_____

_____

(Full name and address of person, institution, or agency)

such information as may be necessary regarding the treatment of:

_____

(Print or type full name of client/patient/resident)

Purpose or need for disclosure: To provide continuity of care.

Specific information to be disclosed: Medical, psychosocial, occupational, physical, speech and hearing therapy reports. Daily correspondence written or verbal for continuity.

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent (unless expressly revoked earlier) expires upon:

School year :_____

_____

(Specify date, event, or condition upon which it will expire)

_____

(Signature of parent, legal guardian or person authorized to consent)

Relationship: _____

Date: _____

Witness: _____

09/05