The Lili Claire Foundation/ UNSOM Developmental Behavioral Clinic
Authorization for the Release of Medical Information

Patient's Name:____

DOB:_______________________________ Social Security # _________________________________

I consent to the release of medical information from my patient record by:

Dr. Johanna S. Fricke or Dr. Julie Beasley
Kids Health Care/ LCF Clinic
3006 S Maryland Parkway #315
Las Vegas, NV 89109
(702) 992-6833 Office (702) 992-6830 Fax

TO:

Name of Facility: ____

Address: ____

Phone: ___________________________ Fax: ___________________________

Name of Facility: ____

Address: ____

Phone: ___________________________ Fax: ___________________________

Name of Facility: ____

Address: ____

Phone: ___________________________ Fax: ___________________________

The information I authorize to be released is:

☐ *Entire Client File* ☐ *Psychiatric Assessment* ☐ *Progress Notes*
☐ *Medication Records* ☐ *Psychiatric Diagnosis* ☐ *Psychological Test Results*
☐ *Consultation Reports* ☐ *Other* ____

This consent is effective ___________ and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization will expire (1) year from the date of signing.

I have been fully informed of my rights to the confidentiality of my records. I understand this is a required consent and that I must voluntarily and knowingly sign my consent prior to any records being released. If I choose not to sign this release, my records cannot and will not be released. I further release doctors and staff of University of Nevada, School of Medicine and The Lili Claire Foundation and its officers, directors, employees and agents from any liability resulting from the release of information to the person/agency designated above.

____ _________________________________

Signature (Parent or Guardian if Minor) Date

____ _________________________________

Witness Date