



*The Lili Claire Foundation/
UNSOM Developmental Behavioral Clinic
Consent and Request to Release Information*



Patient's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip _____

Parent/ Legal Guardian Name _____

Please list below the hospital of birth and any other medical centers where the child was treated, doctors, agencies, schools, or other that we are hereby authorized to contact regarding the diagnosis and treatment of the child. Parents/Guardians you are still responsible for obtaining copies of these records before initial appointment. Photocopy shall be valid as original.

Name of Facility: _____
Address: _____
Phone: _____ Fax: _____

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Address: _____
Phone: _____ Fax: _____

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Address: _____
Phone: _____ Fax: _____

Name of Facility: _____
Address: _____
Phone: _____ Fax: _____

Name of Facility: _____
Address: _____
Phone: _____ Fax: _____

Signature (Parent or Guardian if Minor)

Date

Witness

Date