



Authorization for Release of Health Information

1247 S. Cedar Crest Blvd, Suite 101 • Allentown, PA 18103
610-770-1800 • www.everychildeverytime.com

Please complete this Authorization in its entirety. Incomplete forms may delay timely processing and/or may be returned to the patient for additional information.

I hereby authorize Children's Integrated Center for Success (CICS) to release, obtain, or exchange medical/behavioral health information from the records of:

Patient Name:	
Patient Date of Birth:	
Patient Address:	
Patient Phone:	

This authorization is valid only for the release or exchange of information with the following entity:

Name of Person or Entity:	
Address:	
Phone:	
Fax:	
Email:	
Relationship to Patient:	Parent/ Guardian Medical Professional School Employer Other:
Records are requested for the following purposes:	Continuing Care Legal Personal Insurance Other:

How would you like the requested information to be shared with this entity? (Please circle):

Fax	Email	Mail	Verbal Communication	Will pick up from CICS
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Please indicate the Fax number, Email or Mailing Address you would like records sent to if different than above:

