

Institute for Personal Development

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Also Serving: Aurora a& Ottawa

Verbal Authorization to Release Information

I authorize representatives of Institute for Personal Development to verbally communicate with the following individual/office for the purpose (check all that apply) of:

_____ Billing Questions _____ Scheduling Appointments _____ School Medications

(Name of Facility or Clinician)/Nature or Relationship to Patient

(Address)

(City, State, Zip)

(Phone Number)

(Fax Number)

The following information on _____
(Patient's Name) (Date of birth)

This Release is valid for the period of one year from the date of authorization unless revoked in writing.

Signature of Patient/Responsible Party if Minor (12 years and older must sign release)

Date

Signature of Witness

Date

*** All patients 12 years of age or older need to sign this authorization to release.***

Updated: 12/2014