



**AUTHORIZATION TO RELEASE INFORMATION  
TO OR FROM INTERPLAY**

**Concerning:** \_\_\_\_\_  
**Name of the Child**

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information for payments or administrative operations or as it relates to treatment.

I understand that I have the right to know at all times what information is shared regarding my self or my child. I understand that the identity of the designated parties must be verified before the release of my information. I know that I have the right to revoke this authorization at any time in writing.

Name: \_\_\_\_\_ Relationship: **PHYSICIAN**  
Purpose: \_\_\_\_\_  
Address to which information is sent: \_\_\_\_\_  
Type of information released: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: **TEACHER**  
Purpose: \_\_\_\_\_  
Address to which information is sent: \_\_\_\_\_  
Type of information released: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Address to which information is sent: \_\_\_\_\_  
Type of information released: \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_

**Parent Print Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_