I,                          , parent or guardian of:

 (Print Full Name) (Child’s Full Name) (Child’s DOB)

Hereby authorize the release of my child’s health information

From/to:

 Name: Dr. Kelsey Lisle & Bay Kids FL Inc.

 Address: 111 2nd Ave NE, Suite 906

 City, State, Zip: St. Petersburg, FL 33701

 Phone: (833) 375-4753

 Email: DrLisle@BayKidsFL.Com

From/to: (List all applicable-referral sources, schools, therapists, doctors that you authorize us to collaborate with)

**Name:**

Phone:

Email:

Address:

City, State, Zip:

**Name:**

Phone:

Email:

Address:

City, State, Zip:

**Name:**

Phone:

Email:

Address:

City, State, Zip:

**Name:**

Phone:

Email:

Address:

City, State, Zip:

I understand and acknowledge that this may include alcohol/drug abuse, mental health, and/or HIV/AIDS information.

Purpose of disclosure:

Information Requested:

I give my permission for the information listed above to be released to the above named requestor. I understand that I may receive this authorization at any time, expect to the extent that action has already been taken to comply with it. This authorization will expire 120 days after the date signed. The requestor should not redisclose my medical records to another party without further written consent.

I will not hold Dr. Kelsey Lisle nor the staff of Bay Kids FL Inc. liable for any injury, whether mental or physical, resulting from my misunderstanding of information in the released report as a result of my not asking for clarification of the information therein.

Date:                      Signature:

 (Patient or Legal Representative)

Date:                      Witness: