Medical Records Release

Please complete the following information.

I, _________________________, hereby authorize **Calo**, to release verbal and written Information

and documentation pertaining to the placement and treatment of the following

Individual: _________________________________ to ___________________________________

at ____.

The information specifically being requested is checked below:

☐Treatment Plans	☐Treatment Summaries	☐Psychiatrist Visit Notes
☐Progress Notes	☐Safety Assessments	☐Immunizations/Updates
☐Academic Records	☐Discharge Summary	☐ Other ________________

By signing, I am agreeing to the release of all pertinent information concerning the care, treatment and progress at Calo, as well as well as insurance documentation and billing (if applicable).

This release will be effective for one year unless otherwise noted:__________.

_____________________________________ Signature

__________________________ Relationship

_____________________ Date

Please email, mail, or fax this form to:
ATTN: Medical Records
130 Calo Lane
Lake Ozark, MO 65049
Fax: 573-365-2224
Email: UR@caloprograms.com