HUMANITARIAN FOUNDATION

A CHARITABLE TRUST OF

GROTTOES INTERNATIONAL

430 Beecher Rd, Gahana, OH 43230-1797 | Phone: (614) 933-0711 | Email: hf@hfgrotto.org

Letter of Diagnosis

Patient Name:	
Patient DOB:	
Diagnosis:	
Today's Date:	
Date of Last Visit:	

Parental Consent

☐ I, the undersigned parent or legal guardian of the minor child identified in this form, hereby authorize the minor's licensed Primary Care Physician and/or Psychologist, as listed below, to disclose and share clinical information and protected health information (PHI) — including diagnosis, treatment history, and any other records relevant to my child's condition — with the Humanitarian Foundation Supreme Council and its authorized representatives. This authorization is granted solely for the purpose of enabling the Humanitarian Foundation to determine my child's eligibility to receive a dental grant. I understand this authorization is voluntary, may be revoked by me in writing at any time, and will otherwise remain in effect until the eligibility determination has been completed.

_____ _____

Signature Date:

PCP/Psych Name:	
Email:	
Phone:	
License Number:	

***For Autism or Downs Syndrome Diagnoses Only see below:**

☐ I certify that I am a licensed healthcare provider and have evaluated this child. Based on my clinical assessment, the child has been diagnosed with an intellectual disability and demonstrates developmental functioning that is at least two (2) years below their chronological age. This determination is supported by medical history, standardized assessments, and/or clinical observation.

_____ _____

Signature Date: