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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I hereby authorize my provider: _____
(Name of provider)

to provide the identified information to and/or receive the identified information from:

Name/Facility: _____
Address: _____
Fax Number: _____ Telephone Number: _____

For the following purpose(s):

_____ At the request of the individual _____ Other: _____

The following information, including identified Protected Health Information is subject to this authorization:

_____ Grades and Report Cards
_____ Attendance Records
_____ Special Education Records (Including MDT & IEP)
_____ Psychological | Neuropsych Evaluation
_____ Standardized Test Scores
_____ Treatment History
_____ Therapy Records/Progress Notes
_____ Drug and Alcohol Evaluation
_____ SCIP Evaluation
_____ Other: _____

This authorization will remain in effect for one year from the date signed below or until _____ (whichever is sooner) and may be received or released in written form, verbally, via telephone, facsimile, e-mail or other electronic means or any other medium agreeable to both parties.

My signature below indicates that I have read and understood this document. I understand I may revoke this authorization at any time by sending written notice to the person/facility releasing records. Such revocation is not valid if (1) action was taken previously in reliance on this authorization or (2) this authorization was obtained as a condition for obtaining insurance coverage. I understand information released may include reports relating to mental or behavioral health and substance use. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or my eligibility for benefits.

I understand and agree that this form may be duplicated for the purpose of requesting records. Copies or faxes of this release are to be accepted as the same as the original document. Confidentiality of this information is protected by federal law and no further disclosure is permitted without written consent of the undersigned.

_____ _____
Signature of Patient | Parent | Legal Guardian Date