Gulf Breeze ABA

Authorization to Release Information

1. Client Name: _____ DOB: _____

2. I am requesting that information be released from: Name: _____

Organization: _____ Contact Information: _____

3. I am requesting that information be released to: Name: _____

Organization: _____ Contact Information: _____

4. I give permission to release the following information:

_____ Diagnostic Assessment _____ Treatment Plan

_____ Treatment Summary _____ IEP

_____ Case collaboration _____ Other: _____

By checking items above, you are giving permission for written information to be released and for the person named in section 2 to talk to the person named in section 3 about your health information.

5. I am requesting that information be released for the purpose of:

_____ Coordination of care _____ Requesting services

_____ Other: _____

6. I understand that by signing this form, I am requesting that the health information specified in Section 4 be sent to the third party named in section 3. I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 2. If the organization, facility or professional named in section 2 has already released health information based on my consent, my request to stop will not work for that health information. I understand that when the health information specified in section 4 is sent to the third party named in section 3, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that if the organization named in section 3 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. If I choose not to sign this form and the organization named in section 3 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care. This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

7. Date: _____ Client Signature: _____

OR legally authorized representative's signature: _____

Representative's relationship to patient (parent, guardian, etc.): _____