Behavior Management Systems, Inc.

7550 Highway 107
North Little Rock, Arkansas 72120

Authorization Form

This form when completed and signed by you, authorizes your psychologist and Behavior Management Systems to release protected information from your clinical record to the person you designate.

I authorize my psychologist, Edward C. Kleitsch, Ph.D. and/or Behavior Management Systems to release a copy of my medical record in accordance with HIPAA regulations.

This information should only be released to (name and address of person to whom the information is to be released)

Name: ______________________________

Address: ______________________________

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I am requesting my psychologist to release this information as a result of my psychologist's retirement from the practice of psychology.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Behavior Management Systems, 7550 Highway 107, Sherwood, AR 72120. However, your revocation will not be effective to the extent that your psychologist or Behavior Management Systems has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist will provide me with a list of potential referral sources should I need additional psychological services. I hereby (request/do not request) this information.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

______________________________ ______________________________
Signature of Patient Date

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If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.