Authorization to Release Information

A. I, _____ (patient's name), DOB _____ (patient's DOB), do hereby consent to and authorize Lisa Rinaldo, Licensed Behavior Analyst, Hudson Valley Licensed Behavior Analyst, P.C., including employees to disclose/obtain from:

Name of person/facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

B. I hereby (do/do not) authorize the source named above to send, as promptly as possible, the records listed below to Hudson Valley Licensed Behavior Analyst, P.C.

□ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness: _____
□ Date(s) of inpatient admission & discharge: _____

□ Start of outpatient treatment: _____ End of treatment: _____

□ Other identifying information about the service(s) rendered: _____

□ Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.

□ Psychiatric evaluations, reports, or treatment notes and summaries.

□ Treatment plans, recovery plans, aftercare plans.

□ Admission and discharge summaries.

□ Social histories, assessments with diagnoses, prognoses, recommendations, and all similar documents.

□ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work.

□ Workshop reports and other vocational evaluations and reports.

□ Billing records.

□ Academic or educational records.

□ Report of teachers'/staff observations.

□ Achievement and other tests' results.

□ A letter containing dates of treatment(s) and a summary of progress.

□ Drug and Alcohol information contained in these records will be released

□ HIV-related information and contained in these records will be released

□ Other: _____

C. I further authorize the source named above to speak by telephone with staff of Hudson Valley Licensed Behavior Analyst, P.C. (identified in the letterhead) about the reasons for my/the patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's receiving treatment or being evaluated or referred elsewhere.

D. I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan. The information disclosed may be used in connection with my/the patient's treatment.

E. This request/authorization to release confidential information is protected by Federal Regulation 42CFR Part 2, and cannot be released without my written consent unless otherwise required by law. I understand that I need not consent to the disclosure of information in order to obtain treatment services.

F. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

G. This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the patient, and arising out of an accident, injury, or occurrence to me/the patient. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 365 days from the date I signed it.

H. I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

I. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

_____ _____ _____

Signature of Parent/Guardian Printed name of Parent/Guardian Date