Authorization to Release of Client Records

Client’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Date of request: \_\_\_\_\_\_\_\_\_\_\_ Valid Through \_\_\_\_\_\_\_

I understand the medical records released are confidential. I understand that the specified information to be released may include by is not limited: history, medical diagnoses, and treatment outcomes as it pertains to past and present symptoms related to treatable medical diagnoses within this profession.

This release will remain in effect for two (2) years from the date of request. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I authorize Weathers Developmental & Behavioral Therapy to exchange, release, or obtain information both verbally and in written form.

I hereby authorize Weathers Developmental & Behavioral Therapy to:

\_\_\_ Exchange with \_\_\_\_ Release to \_\_\_\_\_ Obtain from

Organization or Individual receiving/communicating the information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name of Organization or Provider

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address (including city, state, zip) Phone Number

Information to be released or accessed:

\_\_\_\_\_ Treatment Plan(s) \_\_\_\_ Consent/HR form(s) \_\_\_\_\_ Assessment

\_\_\_\_\_ Medical Records \_\_\_\_ Clinical Records (SP, OT, PT, or evaluation)

\_\_\_\_\_ Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_
Parent Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_
Kasi Weathers, BCBA/Owner of WDB Date