Authorization to Release Confidential Information

RE: _____

D.O.B. _____

I authorize Balance & Behavior L.L.C., to

a. Exchange information with

b. Release information to

c. Receive information from

_____

Name of Person, Organization, or Institution

_____

Address

Purpose of Disclosure or at the Request of the Individual:
As the person signing this authorization, I understand that I am giving my permission to the above named entity for disclosure of confidential records. I understand I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my records and is not effective as to records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I understand information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such information was protected by law while solely in the possession of the care entity.

The following information:

- ☐ Medical Records
- ☐ Education / Academic Records
- ☐ Psychiatric Records
- ☐ Behavioral Report
- ☐ Teacher's Report
- ☐ Psychological Evaluation
- ☐ Neurological Evaluation
- ☐ Verbal Evaluation
- ☐ Other Information _____

Approximate Dates of Service _____

For Purpose of _____

Signature of Client / Guardian _____ Date _____

RELEASE VALID FOR (circle one): ONE YEAR TERMINATION OF TREATMENT REVOCATION