A-2-Z Therapy
Guiding Potential, Reaching New Heights

RELEASE OF INFORMATION (ROI) FORM

CLIENT INFORMATION:

Date: / /

Client Name:	
Address:	
Phone Number:	Email Address:

PURPOSE OF RELEASE:

I, the undersigned, authorize A2Z ABA Therapy to release and/or receive information regarding the above-named client for the purposes of:

☐ Coordinating care and treatment.	☐ Insurance authorization and billing.
☐ Educational or therapeutic planning.	☐ Other:

RECIPIENT INFORMATION:

I authorize the disclosure of information to/from the following:

Recipient Name/Organization:	
Relationship to Client:	
Phone Number:	Fax:

Recipient Name/Organization:	
Relationship to Client:	
Phone Number:	Fax:

Recipient Name/Organization:	
Relationship to Client:	
Phone Number:	Fax:

Recipient Name/Organization:	
Relationship to Client:	
Phone Number:	Fax:

INFORMATION TO BE RELEASED:

I authorize the release of the following information:

☐ Diagnosis and treatment records.	☐ Treatment plans and progress notes.
☐ Educational records (e.g., IEP/504 Plan).	☐ Insurance and billing information.
☐ Functional Behavior Assessments (FBA).	☐ Other (specify):

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AUTHORIZATION DETAILS:

This authorization is valid for one year from the date of signature unless otherwise specified:

Expiration Date (if different):

I understand that:

1. I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization.
2. The information disclosed may be subject to re-disclosure by the recipient and no longer protected by HIPAA.
3. I am not required to sign this form to receive treatment, payment, enrollment, or eligibility for benefits.

Acknowledgment and Signature

By signing below, I acknowledge that I have read and understand this authorization.

Signature of Client/Parent/Guardian: _____

Printed Name: _____

Relationship to Client (if applicable): _____ **Date:** _____

Comments: