Consent for Release of Information
AUTHORIZATION TO DISCLOSE PARTICIPANT HEALTH INFORMATION

Participant / Patient Name:_____ Date of Birth: _____

As required by HIPAA Privacy Regulations & applicable portions of the California Welfare and Institutions Code Section 4514, protected health information may not be used or disclosed to a third party without participant authorization.

I consent to, request, and authorize the following agencies to release any or all medical, social, psychological, or educational information regarding the above-named person to Autism Behavior Intervention, Inc. In addition, I consent to, request, and authorize Autism Behavior Intervention, Inc. to release any and all appropriate information in the treatment and/or diagnostic records of the above-named person to the following:

_____ _____
Primary Care Physician / Pediatrician Phone Number

_____ _____
Regional Center Phone Number

_____ _____
School District Phone Number

_____ _____
Health Insurance Company Phone Number

_____ _____ _____
Other Provider Name Provider Type Phone Number

_____ _____ _____
Other Provider Name Provider Type Phone Number

_____ _____ _____
Other Provider Name Provider Type Phone Number

I understand that all such information becomes part of Autism Behavior Intervention, Inc. records and will be utilized for planning services for the above-named person.

I understand that Autism Behavior Intervention, Inc. preserves the confidentiality of client information, and releases information only according to policies based on applicable portions of the California Welfare and Institutions Code Section 4514.

I understand that this Consent for Release of Information is valid for the period of time in which the above-named person is an active client of this center (i.e., one who is receiving services planned, coordinated, delivered, or supervised by Autism Behavior Intervention, Inc.). All or any part of the Consent for Release of Information is cancelled upon receipt of written notification from the undersigned.

Effective date for this authorization: _____/_____/_____

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Participant Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Restrict what is disclosed with this authorization.
6. Receive a copy of this Authorization and understand that a photocopy is as valid as an original.

Name of Parent / Legal Guardian: _____ Date:_____

Parent / Legal Guardian Signature: _____ Relationship to Patient:_____

OR, if you <u>do not</u> wish to grant permission to release information regarding your child, please fill out and sign below.

I, _____ parent/legal guardian of _____
REFUSE TO GRANT permission to COMPANY and its representatives to discuss and/or release information regarding the therapeutic treatment of _____ , DOB_____ with other persons, professionals, institutions/agencies.

_____	_____	_____
Name of Parent/Legal Guardian	Signature	Date