AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

RE: _____
Client Name

_____
Street Address

_____
Date of Birth Phone Number

The undersigned herby authorizes and request the release of confidential health information between Innovations In Learning and:

TO: _____
Institution, Individual, Agency Phone Number

_____
Relationship to Individual

_____
Street Address

Description of Information to be Disclosed:

_____Initial Evaluation
_____Behavior Support Plan
_____Treatment Plan
_____Progress in Treatment
_____Medical Information
_____Discharge Summary
_____Entire Record
Other: _____

Purpose:
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and to coordinate treatment services with other providers.

Revocation and Expiration:
I fully understand that my medical record contains confidential physical, mental health, substance abuse, and/or HIV/AIDS information compiled in the course of my treatment. The medical records and/or information authorized to be disclosed above are privileged and confidential and may be disclosed only on my authorization, as required by law.

I understand that I have the right to revoke this authorization, at any time, by sending written notification to Innovations In Learning. This authorization expires in 60 days after services have been terminated or until all financial responsibilities have been satisfied. Unless otherwise revoked, this authorization expires on _____.

Form of Disclosure:
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

This information is disclosed from records protected by federal confidentiality rules. The federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted. A general authorization for the release of medical or psychological information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse

_____ _____
Client/Guardian Signature Witness Signature

_____ _____
Date Date