BEHAVIOR CARE SPECIALISTS

behaviorcarespecialists.com

Authorization for Release of Information Form - 1

Name _____ _____ _____

Last *First* *MI*

Date of Birth _____/_____/_____ Today's Date _____/_____/_____

I hereby authorize the release and/or exchange of information as described below to:

Behavior Care Specialists, Inc.
1105 W. Russell St.
Sioux Falls, SD 57104

The following documents are authorized for release:

____ Individual Education Plan (IEP)	____ Client information sheet	____ Speech/language evaluation
____ Psycho educational evaluation	____ Hearing screening	____ Individualized treatment plan report
____ Report cards/transcripts	____ Medical history and physical	____ Immunization report
____ Behavioral reports	____ Special report	____ Neurology report
____ Psychiatric evaluation	____ Psychological evaluation	____ Medication management visit
____ Discharge summary	____ Progress notes	____ Other _____

I authorize the following organization(s) to release and/or exchange the information indicated above:

Medical Organization

Clinic/Hospital _____

Doctor _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____-_____ Fax (_____) _____-_____

Clinic/Hospital _____

Doctor _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____-_____ Fax (_____) _____-_____

Authorization for Release of Information Form - 2

Educational Organization

Organization _____

Contact Person _____ _____
Last *First*

Address _____

City _____ State _____ Zip _____

Phone (_____) _____-_____ Fax (_____) _____-_____

Email address _____

Other

Organization _____

Contact Person _____ _____
Last *First*

Address _____

City _____ State _____ Zip _____

Phone (_____) _____-_____ Fax (_____) _____-_____

Email address _____

Organization _____

Contact Person _____ _____
Last *First*

Address _____

City _____ State _____ Zip _____

Phone (_____) _____-_____ Fax (_____) _____-_____

Email address _____

Authorization for Release of Information Form - 3

I understand that:

- The information will be disclosed to assist Behavior Care Specialists, Inc. staff in providing services for the individual whose records are being requested.
- This authorization is voluntary and that I need not sign this form to ensure services.
- I have a right to revoke this authorization at any time by written notification to Behavior Care Specialists, Inc.
- The revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date signed below, unless I indicate an earlier date: _____/_____/_____.
- If the person or entity that receives above information is not a health care provider or plan covered by federal privacy regulations, the information may no longer be protected by federal privacy regulations.
- Information in my health records may include references to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- In order to help assure confidentiality, Behavior Care Specialists, Inc. will send records via first class mail. If necessary, Behavior Care Specialists, Inc. may transmit records by fax or other electronic means to organization(s) or person(s) indicated by this form.
- A photocopy of this form shall have the same force and effect as the original.

I hereby release Behavior Care Specialists, Inc. from all legal responsibility that may arise from the act I have authorized above.

_____ Date _____/_____/_____

Signature of Parent/Legal Guardian

_____ Date _____/_____/_____

Signature of Patient (if indicated)

If patient being referred is 18 years old or older, he/she must sign the release of information him/herself, unless guardianship has been established by a parent or another individual. If guardianship has been established for the individual being referred, please include a copy of the guardianship papers.