



AUTHORIZATION FOR RELEASE OF INFORMATION

BEHAVIOR CARE SPECIALISTS

Changing Behavior, Changing Lives

Client Full Name:	Client Birthdate:
Full Name of Parent/Guardian:	Today's Date:

By signing below, I hereby authorize the release and/or exchange of information as described below to:
 Behavior Care Specialists, Inc. – Central Office
 1105 W Russell St; Sioux Falls, SD 57104
intake@behaviorcarespecialists.com
 FAX: (605) 271-3956

The information will be disclosed to assist Behavior Care Specialists, Inc. personnel in providing services for the individual whose records are being requested.

The following documents are authorized for release:

<input type="checkbox"/> Individualized Education Plan (IEP) and related SPED documents (includes Multi-Disciplinary Evaluations)	<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Behavioral Reports
<input type="checkbox"/> Client Information Sheet	<input type="checkbox"/> Medical history	<input type="checkbox"/> Report cards/transcripts
<input type="checkbox"/> Service, Session, or Behavior Notes	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Hearing Screening
<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Speech/Language Evaluation	<input type="checkbox"/> Progress Reports
<input type="checkbox"/> Neurological Evaluation	<input type="checkbox"/> Diagnostic Evaluations	<input type="checkbox"/> Special Report
<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Functional Behavior Assessments	<input type="checkbox"/> Daily Behavior Data
<input type="checkbox"/> Education or Skills Assessments	<input type="checkbox"/> Medication Management Information	<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> Immunization report		
<input type="checkbox"/> Other; Specify:		

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

Name of person or entity:

Contact Person (if different than above):

Street Address:

City, State:	Zip:
Phone Number:	Fax Number:

Email Address:

This authorization will expire September 1, 2019 or on this date (specified by parent/guardian):

BCS cannot use or disclose certain information unless the patient specifically authorizes such use or disclosure. **Please initial next to each item below if you specifically authorize the release** of health information relating to the testing, diagnosis, or treatment for:

_____ HIV/AIDS
 _____ Drug and alcohol abuse
 _____ Mental health/psychiatric disorders

By checking this box and entering my name below, I acknowledge that this constitutes a legal signature, and I hereby release Behavior Care Specialists from all legal activity that may arise from the act I have authorized above and acknowledge receipt of the Parent/Guardian letter and Authorization for Release of Information on the date set forth below.

(Signature of Parent/Legal Guardian) _____
(Date)

(Signature of Client, if indicated) _____
(Date)

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.

A photocopy or scanned copy of this form shall have the same force and effect as the original.