BEHAVIOR CARE SPECIALISTS

Changing Behavior, Changing Lives

Authorization for Release of Information and Parent/Guardian Letter	
Document Number: 3.2.3	**Reviewed:** January 2019
Department: Client Services	**Next Review:** July 2019
Approved by: COO, CM, attorney	**Date of Origin:** July 2018

Dear Parent/Guardian,

The forms attached to this document will give Behavior Care Specialists, Inc. permission to exchange confidential information about your child with persons or entities of your choice in accordance with HIPPA and FERPA. This will allow us to share and receive information with persons and entities who have served your child in the past, and with those with whom we will coordinate care to serve him/her in the present. Commonly authorized persons or entities are schools, physicians, and related service providers (such as speech or occupational therapists).

We want to ensure that you understand that:

- This authorization is voluntary and that you need not sign this form to ensure services.
- You 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.
- 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.
- As required by HIPAA, you are notified that no treatment, payment, enrollment in a health plan, or eligibility for benefits are being conditioned upon your signing this authorization. Further, as required by HIPAA, upon the provision of the information authorized hereunder such information may not be protected if such information is provided to a non-covered entity as such entities are not prohibited by federal law from re-disclosing such information. Such release could subject BSC to legal consequences, however.
- Records may be sent via first class mail, fax, or encrypted email.

Please direct any questions to the supervisor at your site.

Sincerely,

BCS Administration

For Office Use Only

Instructions:

- Each entity with whom the parent/guardian wishes to authorize an exchange of information must be written on a separate form.
- Make multiple copies of the form for use by the parent/guardian
- Attach all forms to this cover page
- List persons or entities authorized for an exchange of information below

Page #	**Person or Entity**

AUTHORIZATION FOR RELEASE OF INFORMATION

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
contactus@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:

☐ Individualized Education Plan (IEP) and related SPED documents (includes Multi-Disciplinary Evaluations)

☐Client Information Sheet	☐Treatment Plans	☐Behavioral Reports
☐Service, Session, or Behavior Notes	☐Medical history	☐Report cards/transcripts
☐Psychological Evaluation	☐Discharge Summary	☐Hearing Screening
☐Neurological Evaluation	☐Speech/Language Evaluation	☐Progress Reports
☐Genetic Testing	☐Diagnostic Evaluations	☐Special Report
☐Education or Skills Assessments	☐Functional Behavior Assessments	☐Daily Behavior Data
☐Immunization report	☐Medication Management Information	☐Psychiatric Evaluation

☐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.