AUTISM BEHAVIORAL CONSULTING
AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME _____ _____ _____
LAST FIRST MI
DATE OF BIRTH _____/_____/_____

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

Autism Behavioral Consulting
3200 W. 49TH Street
Sioux Falls, SD 57106

The following documents are authorized for release:

____ INDIVIDUAL EDUCATION PLAN (IEP)
____ CLIENT INFORMATION SHEET
____ HEARING SCREENING
____ REPORT CARDS/TRANSCRIPTS
____ IMMUNIZATION REPORT
____ SPECIAL REPORT
____ PSYCHIATRIC EVALUATION
____ MEDICATION MANAGEMENT VISITS
____ OTHER _____
____ SPEECH/LANGUAGE EVALUATION
____ PSYCHO EDUCATIONAL EVALUATION
____ INDIVIDUALIZED TREATMENT PLAN REPORT
____ MEDICAL HISTORY & PHYSICAL
____ BEHAVIORAL REPORTS
____ NEUROLOGY REPORT
____ PSYCHOLOGICAL EVALUATION
____ DISCHARGE SUMMARY
____ PROGRESS NOTES

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 (_____) _____-_____

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 _____

I understand that:

- The information will be disclosed to assist Autism Behavioral Consulting (ABC) staff in providing services for the individual whom 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
- The revocation will not apply to information that has already been released in response to this authorization.
- This authorization will not expire. If I do not agree with this, this is the date that this release will expire _____
- 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, ABC will send records via first class mail. If necessary, ABC 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 ABC from all legal responsibility that may arise from the act I have authorized above.

If client being referred is 18 years old or older, he/she must sign the Release of Information, unless guardianship has been established. If guardianship has been established for the individual being referred, please include a copy of the guardianship papers.

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

_____ _____/_____/_____
Signature of Client (if, over 18 and they are their own guardian) Date