AUTHORIZATION TO DISCLOSE AND/OR EXCHANGE OF MEDICAL, BEHAVIORAL, EDUCATIONAL AND/OR OTHER PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

SPECIFY RECORDS, PERSONS, AND FACILITIES

- Check the box to choose the type of information to disclose.
- List the name, facility, and contact information to authorize for Behavioral Concepts' designated employees to exchange protected health information.

| | Medical Information: Diagnostic evaluation and summary, birth records, office visits, physical examination, developmental assessments, hospital admission discharge summaries.
and

Physician Name & Hospital Name: _____

| | Educational Records: School assessments and Individualized Education Plan (IEP)

School Psychologist, Teacher, Behavior Analyst, Speech Pathologist, Occupational Therapist & Name of School & District:_____

_____

| | Psychiatric/Psychological Information: mental health evaluation and treatment records, psychological/ psychiatric diagnostic assessments including testing scores, medication information.

Psychologist and/or Psychiatrist Name & Facility Name: _____

| | Behavioral Health Information and/or Other Related Therapies: review of previous behavior service reports, assessment and progress reports from Speech Pathologist, Occupational Therapist, Physical Therapist, and/or related therapies.

Speech Pathologist, Occupational Therapist, Physical Therapist, Behavior Analyst & Facility Name(s): _____

_____

| | Regional Center: developmental assessment, regional center documents, Individualized Program Plan (IPP)

Service Coordinator Name & Regional Center: _____

| | Insurance Health Plan: _____ | | Other (specify) _____

I hereby authorize the above named health plan, medical practitioner, hospital, clinic, mental health facility, regional center, school and/or its designated employees to exchange/receive the protected health information and/or educational records regarding the individual/patient indicated withm Behavioral Concepts. and/or its designated employees.

DURATION: The authorization shall become effective immediately and shall remain in effect until_____ (enter date) or for one year from the date of signature if no date is entered.

REVOCATION: This authorization may be revoked by the undersigned at any time. The revocation must be in writing, signed by the undersigned, and sent to Behavioral Concepts by fax (714) 242-1611 or email info@bc-aba.com. Written revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.

REDISCLOSURE: Behavioral Concepts may not re-disclose the information obtained under this authorization unless additional authorization is obtained or disclosure is specifically required or permitted by law.

I request that the health information released pursuant to this authorization be used for the following purposes only: behavioral health treatment for autism. I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I have a right to receive a copy of this authorization for my records. A copy of this authorization is valid as an original.

Signature of patient or patient's legal representative_____ Date_____

Printed Name_____ Relationship if signed by someone other than the patient_____