AUTISM BEHAVIORAL CONSULTING AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME				
LAST	FIRST	MI		
DATE OF BIRTH/				
I hereby authorize the release and/or exchar	nge of information as described below	to:		
Autism Behavioral Consulting				
3200 W. 49 [™] Street				
Sioux Falls, SD 57106				
The following documents are authorized for	release:			
INDIVIDUAL EDUCATION PLAN (IEP)	SPEECH/LANGUAGE EVALUA	TION		
CLIENT INFORMATION SHEET		PSYCHO EDUCATIONAL EVALUATION		
HEARING SCREENING	INDIVIDUALIZED TREATMEN	INDIVIDUALIZED TREATMENT PLAN REPORT		
REPORT CARDS/TRANSCRIPTS	MEDICAL HISTORY & PHYSIC	MEDICAL HISTORY & PHYSICAL		
IMMUNIZATION REPORT	BEHAVIORAL REPORTS	BEHAVIORAL REPORTS		
SPECIAL REPORT	NEUROLOGY REPORT	NEUROLOGY REPORT		
PSYCHIATRIC EVALUATION	PSYCHOLOGICAL EVALUATIO	PSYCHOLOGICAL EVALUATION		
MEDICATION MANAGEMENT VISITS	DISCHARGE SUMMARY	DISCHARGE SUMMARY		
OTHER	PROGRESS NOTES			
MEDICAL ORGANIZATION CLINIC/HOSPITAL				
DOCTOR				
ADDRESS				
CITY	STATEZIP			
PHONE ()	FAX ()			
CLINIC/HOSPITAL				
DOCTOR				
ADDRESS				
CITY	STATEZIP			
	FAX ()			
EDUCATIONAL ORGANIZATION				
CONTACT PERSON				
LAST	FIRST			
— ···				
ADDRESS	STATEZIP			
PHONE () -	FAX ()			
EMAIL ADDRESS				

OTHER

CONTACT PERSON LAST ADDRESS CITY PHONE (FAX ()	ORGANIZATION			
ADDRESS CITY STATE ZIP PHONE (CONTACT PERSON			
PHONE FAX (EMAIL ADDRESS	LAST		FIRST	
PHONE FAX (EMAIL ADDRESS	ADDRESS			
PHONE FAX (EMAIL ADDRESS	CITY	STATE	ZIP	
ORGANIZATION CONTACT PERSON LAST FIRST ADDRESS CITY STATE 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.	PHONE ()	FAX ()		
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CITY				
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Signature of Parent/Legal Guardian Date	been established. If guardianship has k			· ·
Signature of Parent/Legal Guardian Date			/	/
	Signature of Parent/Legal Guardian		Date	

Date

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