AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the supervision of Sindy Victor, MS, BCBA, LBA.

I hereby authorize Swarthy Lion Behavioral Health & Wellness LLC to (check all that apply):

____ Exchange information with

____ Release information to

____ Obtain information from

The following Organization/Individual in regard to the above named patient:

Name of Organization/Individual: _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

I hereby authorize this information to be exchanged in the following manner(s):

____ Verbal only

____ Written form only

____ Both verbal and written communication

Description of information to be exchanged / released / obtained (select all that apply):

____ Education records

____ Evaluation/assessment/eligibility records

____ Medical records

____ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

Other: _____

This information is to be used for diagnostic, treatment planning and continuity of care purposes only.

This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing. From _____(MM/DD/YYYY) To _____(MM/DD/YYYY)

_____ _____

Parent/Guardian Printed Name Date

_____

Parent/Guardian Signature

For Office only:

Records Released by: _____ Date: Released: _____