**AUTHORIZATION FOR RELEASE OF PROTECED HEALTH INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby authorize Autism Spectrum

 (Patient Name/Legal Representative)

Diagnostics and Consulting to release protected health information from the records of:

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To**:

Name of Individual or Organization

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address City, State, Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Number Fax Number

**For the purpose of**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be Released (Please check all that apply):**

☐ Psychological Evaluation/Reports ☐ Mental Health History

☐ IEP/504 Plans/Report Cards ☐ Medical History and Physical

☐ Therapy Notes ☐ Discharge Summary

☐ Progress Notes ☐ Imaging Reports (CT, MRI, etc.)

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been informed of the type of information being released; the benefits and disadvantages and I understand that services are not contingent upon my decision concerning the signing of this release. I understand that my records are protected under state and federal law and cannot be disclosed without my written consent unless otherwise permitted in accordance with state and federal law. Autism Spectrum Diagnostics and Consulting may deny this request under limited circumstances as provided for by the state and federal law. I understand that I can revoke this authorization at any time (in writing) except to the extent that action has already been taken. I understand that this authorization will automatically expire in 12 months.

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Signature of Patient (Legal Representative) Date