Authorization for Release Form

If your child has a specific diagnosis of Autism Spectrum Disorder F84.0 we need a copy of the diagnostic reports sent from the diagnosing doctor. Please include a copy of the report if you have it in your possession. If you do not have a copy available to share with us, please fill out the attached form. The Agency or Individual should be your child’s diagnosing physicians name. Please don’t forget to fill out the back of the form and sign it.

Thank you,

Children’s Behavioral Services, LLC

Authorization for Release to Children’s Behavioral Services, LLC

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (parent/legal guardian name) do hereby authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Diagnosing doctor or clinic) to release records to **Children’s Behavioral Services, LLC.** Medical information relating to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child’s name) in said facility for the following purpose only:

Include also the following specific type data (check all that apply)

( x ) Diagnostic Reports

( ) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:

* The expiration date or expiration event for this authorization is\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* If no expiration date or period is known it will expire six (6) months after the date recorded below.
* This authorization covers only treatment prior to the date recorded below.
* I understand I may revoke this authorization at any time with a written request to the above-named facility.
* The request to revoke authorization must contain the signature of the patient or the patient’s legal representative and must be notarized.
* Revocation of this authorization is allowable only to the extent that the release of information has not already occurred and/or only if facility has not taken action in reliance thereon.
* I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.
* I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of this information.
* This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.

Children’s Behavioral Services, LLC is hereby released from all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the applicable federal law.

Signature of Patient or Authorized Individual Date

Relation if Signed by Other than Patient

Patient Social Security Number DOB

Address