CARE
Reach fullest potential!

Authorization to Release Information

This consent form is designed to allow CARE to exchange information with other providers involved in the client's care. This will allow CARE to either obtain relevant records to help us provide thorough and complete care to the client and/or allow us to share records with other providers in order to coordinate care.

CLIENT INFORMATION:

Client's Name: _____ DOB:_____

Street Address, City, State, Zip**:** _____

I hereby authorize CARE Inc. to (check all that apply):

☐ Exchange with ☐ Release to ☐ Obtain from

The parties that I have indicated below:

_____

_____

Description of information authorized to be released, obtained or exchanged. This information may be released verbally and in writing (check specific records to be released):

__ Education records
__ Progress report/notes
__ Evaluation & assessment report
__ Emergency Room or urgent care records
__ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)
__ Records from private physician including specialists
__ IEP/IFSP/IEE/FBA/FAA
__ Treatment summary
__ School observations
__ Social worker notes
__ Other _____

The purpose of this release is: _____

This authorization expires: One year from today (_____) Date:_____

I hereby understand and acknowledge the following:

- *I may request a listing of all records released*
- *I have a right to see my record and request an amendment to my record*
- *I understand that the information in client's records may include sensitive information regarding medical history, and behavioral or mental health services and treatment*
- *CARE Inc., as the sending agency, cannot guarantee that the Receiving agency will not re-disclose my information to a third party*
- *CARE Inc., as the Receiving agency, will maintain any received information under strict guidelines for the maintenance of confidentiality*
- *This consent of disclosure will expire ninety (90) days after the termination of services, or as otherwise specified by date, event, or condition as follows, unless previously revoked by me*
- *I may revoke this authorization by submitting the revocation request in writing to CARE Inc. at any time. Any revocation will not be effective to the extent that action has already been taken based on the original authorization, or where CARE Inc. requires the information in order to be paid for treatment provided to me*

By signing, I acknowledge that I have read and agree to all the conditions specified in this consent form. I acknowledge the permission I have given CARE Inc. to release, obtain or exchange information with the specified providers (listed above).

Print Name, client, parent or legal guardian (First & Last):_____

Signature of client, parent or legal guardian: _____ Date: _____

Print Name of interpreter/witness (First & Last): _____

Interpreter/witness (**If applicable**. First & Last): _____ Date:_____