AUTHORIZATION TO RELEASE INFORMATION

Patient Name: (Last/First MI)_____

Date of Birth: _____ / _____ / _____

I hereby give my permission to Family Achievement Center, Inc.

TO:

- ☐ Disclose to
- ☐ Obtain/receive from
- ☐ Exchange with

With the following organization / person(s) below:

Name:_____

Facility:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: (____)_____ Fax: (____)_____

I wish to have the following information released:

☐ OT Records ☐ PT Records ☐ ST Records
☐ Evaluation Reports ☐ Plan of Care ☐ Assessment
☐ Medical Reports ☐ Daily Notes ☐ Discharge Report
☐ Recommendations ☐ General Verbal Communication
☐ School Adjustments ☐ X-Rays
☐ Summary of Contacts ☐ Other: _____

☐ ISP ☐ IEP ☐ IPP ☐ PIP ☐ IHP ☐ IDEA ☐ IFSP

We **cannot** release the following information unless the patient or his/her legal guardian **initials** the line next to it.

☐ Psychology _____ ☐ Neuropsychology_____ ☐ Psychiatric_____ ☐ Social Work_____

[illegible] **[illegible]**

☐ Continuing Care ☐ Insurance ☐ Litigation ☐ Personal ☐ Education ☐ Other_____

I understand that:

- I may revoke this authorization at any time by **written request**
- Revoking my authorization will **NOT** apply to information already released in response to this authorization
- A photocopy or facsimile of this authorization will be treated in the same manner as if it were the original form
- Once information is released because of this authorization, Family Achievement Center cannot prevent re-disclosure of the information to a third party
- Family Achievement Center may not make treatment, payment or eligibility for benefits a condition of my signing this form
- I understand that I will get a copy of this form after I sign it
- **This authorization expires one year from the date I sign**

_____ _____ _____ / _____ / _____
Signature of Patient, Parent / Legal Guardian Relationship Date

==========OFFICE USE ONLY==========

Date Received:_____ Date Processed:_____ Request Completed By:_____ ID Check:_____