Authorization to Disclose Protected Health Information

_____________________________________ _________________

Client Name Date of Birth

I authorize Precision ABA, LLC to release the following protected healthcare information via phone, email, fax, or letter regarding the above-mentioned person:

All Pertinent Information

*I do not authorize Precision ABA, LLC to release the following information*_____

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to:

____

Individual, Facility or Organization Phone Number

____

Address Fax or Email Address

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City, State, Zip Code Fax or Email Address

The purpose or need for this information is:

Continuation of Treatment

I understand that if I do not sign this Authorization, Precision ABA, LLC may be hampered in its effort to provide appropriate and effective services to my child. Other consequences of refusal to sign Authorization, if any:

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I understand that I have the right to inspect and copy the information to be disclosed. I understand that such information is confidential and is protected by federal and state law. I understand that I have the right to revoke this authorization at any time by giving written notice to Precision ABA, except to the extent that action has already been taken in reliance on it. This authorization **will expire one year** from the signature date.

_______________________________________ ______________________________

Signature (if at least 12 yrs old) Date

_______________________________________ ______________________________

Guardian Relationship to Client