Authorization to Disclose Protected Health Information

Client Name _____ Date of Birth _____

I authorize Precision ABA, LLC to release all pertinent protected healthcare information to the person listed below via phone, email, fax, letter, or other form of communication regarding the above-mentioned person.

Individual, Facility or Organization Name _____ Phone Number _____

Address _____ City _____ State, Zip Code _____

Email Address _____ Fax Number _____

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

_____

The purpose or need for this information is:
Continuation of Treatment and Coordination of Care

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:_____.

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.

Client Signature (if at least 12 yrs old) _____ Date _____

Parent/Guardian Signature _____ Relationship to Client _____