5960 Fairview Road, Suite 300
Charlotte, NC 28210
Tel: 704-441-8715
www.autism-180.com
info@autism-180.com

Request/Authorization to Release Confidential Medical & Mental Health Records and Information

Source of Information

Person or facility: _____
Address: _____
Phone Number: _____

Identifying Information

Name: _____
Address: _____
_____
Phone: _____ DOB: _____ Social Security #: _____
Parent/Guardian: _____
Address:_____
_____Phone Number: _____

I hereby authorize the source named above to send, as promptly as possible, the records marked below to Autism180. (The items not to be released have a line drawn through them.)

Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness:

Date(s) of inpatient admission: _____ Date(s) of discharge: _____
Start of outpatient treatment: _____ End of treatment: _____
Clinical/Client #: _____

Other identifying information about the service(s) rendered:_____

Psychological evaluation(s) or testing records, and behavioral observations or checklists completed by any staff member or by the client.

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Psychiatric evaluations, reports, or treatment notes
Treatment plans, recovery plans, aftercare plans
Admission and discharge summaries
Social histories, assessments with diagnosis, prognosis, recommendations, and all similar documents
Information about how the client's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work
Workshop reports and other vocational evaluations and reports
Billing records

Academic or educational reports
Report of teachers'/staff observations
Achievement and other tests results
A letter containing dates of treatment(s) and a summary of progress
Other: _____

I further authorize the source named above to speak by telephone with staff of Autism180 about the reasons for my/the client's referral, and relevant history or diagnosis, and other similar information that can assist with my/the client's receiving treatment or being evaluated or referred elsewhere.

I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records.

I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan. The information disclosed may be used in connection with my/the clients treatment.
In consideration of this consent, I hereby release the source of the records from any and all liability arising there from.

This request/authorization is valid during the pendency of any claim or demand made by or on behalf of me/the client and arising out of an accident, injury, or occurrence to me/the client. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 365 days from the date I sign it.

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I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness if necessary.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

_____
Signature

_____
Printed Name

_____
Date

_____
Signature of parent/guardian/representative

_____
Printed Name

_____
Date