starBRIGHT
Applied Behavior Analyst PLLC

Telephone: 845-863-5208

www.StarBrightaba.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 StarBright ABA at 118 River Road, Suite 14 Harriman, NY 10926. (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.

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 StarBright ABA 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.

I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releasor, 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