Behavior Central Solutions, Inc.

www.centralbehavior.com
Phone: 407-796-8235 *Fax:* 407-329-4180

Authorization for Behavior Central Solutions, Inc. to Obtain Protected Health Information

Patient's Name: _____ **DOB:** _____

Parent Name: _____ **Phone Number:** _____

I hereby authorize Behavior Central Solutions, Inc. to obtain my child's Protected Health Information from the following organization(s) and/or person(s).

Doctor or Facility Name: _____

Address: _____

Phone Number: _____ **Fax Number:** _____

Description of information to be obtained:

❒ Education records

❒ Evaluation/assessment/eligibility records

❒ Medical records

❒ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

❒ **Other:** _____

Duration of release (check one):

❒ This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.

❒ From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

The purpose if this release is: **Obtain ABA Services at the request of the parent**

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Privacy Officer. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Behavior Central Solutions may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations. I agree that a copy of this release or fax of this release shall be as valid as the original release. If I authorize Behavior Central Solutions, Inc. to fax information, I realize there are inherent risks in faxing Protected Health Information; I understand I will get a copy of this form after I sign it.

_____ _____

Printed Name of Parent/Legal Guardian | Relationship to Patient

_____ _____

Signature of Parent/Legal Guardian | Date

PLEASE FAX REQUESTED RECORDS TO 407-329-4180