BSC
BEHAVIORAL SCIENCE CENTER
3623 CALVIN DRIVE
COLUMBUS, GA 31904

Authorization to Release Information

Client Name: _____ DOB: _____

Street Address:_____City/State: _____ Zip: _____

I understand this release is voluntary and applies to applied behavior analysis treatment under Behavioral Science Center, LLC. I understand that my personally identifiable information (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to redisclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility enrollment determinations. I understand that I may revoke this authorization at any time by notifying Behavioral Science Center, LLC in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.

I hereby authorize Behavioral Science Center, LLC to:
___ Exchange with ___ Release to ___ Obtain from **the parties I have indicated below**

I hereby authorize Behavioral Science Center, LLC to: exchange/release/obtain information:
___ Verbally only ___ in written form only ___ Both Verbally and in Writing

Individuals receiving/Communicating Information:

1. Name of Company/Organization/Person: _____

Contact: _____

2. Name of Company/Organization/Person: _____

Contact: _____

3. Name of Company/Organization/Person: _____

Contact: _____

Description of Information to be exchanged/release/obtained:

_____ All minimum necessary health information to assist in my treatment

_____ Other:

Duration of Release (Check one):
___ This release will remain in effect for two years, unless otherwise stipulated or revoked in writing

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

_____
Signature of Client or Legally Authorized Representative Date

_____
PRINT NAME and Relationship of Legally Authorized Representative to Student/Consumer/Patient