Blue Skies ABA
2800 Scenic Dr, Ste 12
Blue Ridge, GA 30513
Phone: 706-946-0466
Fax: 888-974-1438

AUTHORIZATION TO RELEASE INFORMATION

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

Street Address: _____ **City/State** _____ **ZIP** _____

I understand this release is voluntary and applies to all programs and services operated under the auspices of Blue Skies ABA, Inc. 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 re-disclosure 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 or enrollment determination . **I understand that I may revoke this authorization at any time by notifying Blue Skies ABA, Inc. in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.**

I hereby authorize Blue Skies ABA, Inc. to (check all that apply):

❒ Exchange with ❒ Release to ❒ Obtain from **the parties I have indicated below**

I hereby authorize Blue Skies ABA, Inc. to exchange / release / obtain information:

❒ Verbally only ❒ In written form only ❒ Both verbally and in writing

Service Provided	Organization	Name of Contact	Contact Info
Speech			
OT			
School			
ABA			
Primary Care Doctor			
Psychologist/Psychiatrist			
Other:			
Other:			

Description of information to be exchanged / released / obtained:

❒ Education records ❒ Medical records

❒ Evaluation/assessment/eligibility records ❒ **Other** _____

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

Duration of release (check one):

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

The purpose if this release is: _____

_____

Signature of Student/Consumer/Patient or Legally Authorized Representative **Date**

_____

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