**Authorization to Release Information**

The purpose of this document is to consent and authorize AIBDT to coordinate care with another provider or organization. Coordination of care may include written or verbal communication.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize AIBDT and/or its contractors, to release to and/or obtain the following diagnostic or treatment information in my records:

\_\_\_\_\_ Psychological Evaluation Report \_\_\_\_\_\_Psychiatric Records

\_\_\_\_\_ Psychotherapy Records \_\_\_\_\_\_Medical Records

\_\_\_\_\_ Educational Records \_\_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release of information, as specified above, is authorized to the following provider or organization:

**PROVIDER OR ORGANIZATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROVIDER/ORGANIZATION PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROVIDER/ORGANIZATION FAX NUMBER, IF KNOWN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DIRECT CONTACT PERSON, IF APPLICABLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule. The Consent will expire automatically one year from the date on which it is signed. I understand I may revoke this authorization, in writing, at any time by sending such written notification to my clinician.

Signature of Patient or Parent/Guardian, if patient is under 14 years: \*My attached electronic signature indicates my agreement and consent to the above statements.