



Release of Client Records

Client Name: _____

DOB: _____

Client 18+: YES / NO **If yes, "Client Request Release of Records will be Required"*

Date of Request: _____

Request Made by: _____

Relationship to Client: _____

Date Processed: _____

I, the undersigned, can verify I am the legal guardian/parent of the abovementioned client. I authorize the release of, or request access to the information specified below from the medical record(s) of the above mentioned client.

CLIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care

Personal Use

Social Security/Disability

Insurance

Military

Other: _____

Legal Purposes

School

INFORMATION TO BE RELEASED OR ACCESSED:

Treatment Plan(s)

Consent/HR Form(s)

Supervisor: _____

Behavior Services Contract

Treatment Overview/Report

The above information will be released to:

FULL NAME

DATE

I understand the medical records released are confidential. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include by is not limited to: history, medical diagnoses, and treatment outcomes as it pertains to past and present symptoms related to treatable medical diagnoses within this profession.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Method of Record Delivery: _____

Signature: _____

Parent/Legal Guardian

Signature: _____

OTS Mgmt.