AUTHORIZATION TO RELEASE INFORMATION

Date:

Client Information

Name: DOB:

I understand this release is voluntary and applies to all programs and services operated under Ready Set Connect.

I hereby authorize Ready Set Connect to (check all that apply):

☐Exchange information with

☐Release information to

☐Obtain information from

The following Insurance Company/Organization/Individual regarding the above-named client:

Name of Organization/Individual:

Address:

City: State: Zip:

I hereby authorize this information to be exchanged in the following manner:

☐Verbal only

☐Written form only

☐Both verbal and written communication

Description of information to be exchanged / released / obtained (select (select all that apply):

☐Education records

☐Evaluation/assessment/eligibility records

☐Medical records

Child's Name:		Date of Birth:
Primary Care Provider:	Phone:	Fax:
Diagnosing Provider:	Phone:	Fax:
School:	Phone:	Fax:
Name:	Relation:	Phone:
Name:	Relation:	Phone:
Name:	Relation:	Phone:

If you would like to authorize communication with specific individuals outside of Ready Set Connect, please list them above. (For example, your child's teacher, speech therapist, etc.)

Other:

This information is to be used for diagnostic, treatment planning and continuity of care purposes only. This release will remain in effect until for one (1) year unless otherwise stipulated or revoked in writing.

From (MM/DD/YYYY): To (MM/DD/YYYY):

Client of Parent/Guardian Printed Name: Date:

Client of Parent/Guardian Signature: Date:

Records Released by: Date Released:

Insurance authorization and billing procedures oblige us to send a copy of clinic reports to the primary care physician, or to the physician who referred you or your child for services. We endorse this practice, which facilitates continuity of care.

Admissions and Insurance Contact Information

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