

Client Name:

Date of Birth:

Insurance ID#:

Authorization to Release Information Form

I understand this release is voluntary and applies to all programs and services operated under Ready Set Connect. This information is to be used for diagnostic, treatment-planning, and continuity-of-care purposes only. This release will remain in effect for one (1) year unless otherwise stipulated or revoked in writing.

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

- ☐ Exchange information with
☐ Release information with
☐ Obtain information from

The following Insurance Company / Organization:

<i>Insurance Company Name:</i>	<i>Address:</i>	<i>Phone Number:</i>
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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 all that apply):

- ☐ Education records
☐ Evaluation / assessment / eligibility
☐ Financial records
☐ Medical records

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

<i>Primary Care Provider:</i>	<i>Phone:</i>	<i>Fax:</i>
<i>Diagnosing Provider:</i>	<i>Phone:</i>	<i>Fax:</i>
<i>School:</i>	<i>Phone:</i>	<i>Fax:</i>
<i>Name:</i>	<i>Relation:</i>	<i>Phone:</i>
<i>Name:</i>	<i>Relation:</i>	<i>Phone:</i>

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Insurance authorization and billing procedures oblige us to send a copy of the 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.

<i>Client's Name:</i>	<i>Date of Birth:</i>	<i>Insurance ID #:</i>
<i>Parent / Guardian Name:</i>		
<i>Parent / Guardian Signature:</i>		<i>Date:</i>