Academic and Behavioral Consultation

Release of Information Authorization Form

I _____ the parent/guardian of _____ DOB: _____
(print parent/guardian name) (print child name) (date of birth)
authorize Academic and Behavioral Consultation: 197 Tesuque St. Los Alamos, NM 87544; 505-333-8898 to

- ❑ Obtain Records **FROM** AND/OR
- ❑ Release Records **TO**

Name: _____
Address: _____ Phone: _____

Dates of Records to be released

- ❑ ALL Records to Date OR Specify date range: _____ to _____

Reason for Release: _____

This authority of release of all medical, school, counseling and diagnostic records includes, but is not limited to: medical reports, nurse's notes, x-rays, psychological, psychiatric, laboratory/radiology reports, emergency room reports, physical examinations, progress notes, admission and discharge summaries, all outpatient records, interpretation of diagnostic tests and x-rays, drug and HIV testing data (only if authorized), school records, report cards, Individualized Education Plan (IEP), Student Assistance Team records, developmental/behavioral/social-emotional/speech/occupational therapy/psychical therapy evaluations and reports.
I authorize ALL records to be released except those explicitly listed here: _____
_____

In addition, I specifically acknowledge that such records may include and/or contain reference to any and all of the following subjects, and, by my initials below, direct that all of the following material may be released.

Initial

_____ Records that relate, in any way to drug/alcohol/substance abuse
_____ Records that relate, in any way, to emotional/mental health/psychiatric conditions
_____ Records that relate, in any way, to Human Immune Deficiency Virus (HIV) or to Acquired Immune Deficiency Syndrome (AIDS).

I understand that Academic and Behavioral Consultation understands that records regarding HIV and/or AIDS are protected by state law, and will not further disclose this information without specific written consent from me except where permitted or required by state law.

I understand I have a right to revoke this Authorization at any time. If I revoke this Authorization, I must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and need not sign this authorization to receive services through Academic and Behavioral Consultation. Unless revoked, this authorization will expire on the following date: _____. If no date is specified, this release will expire one year from the date on which it was signed. A copy of this signed authorization will be provided upon request.

An electronic signature with time/date stamp will be considered binding as an original signature. A photocopy of this authorization, which contains my signature, shall be considered effective and valid as the original and shall be honored by those to whom it is provided.

_____ _____ _____
Signature of parent/guardian Relationship to Child Date