Beautiful Autism, LLC

16404 Smokey Point Blvd, Suite 208, Arlington, WA. 98223

My Primary Therapist: _____ Phone: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

Parent/Guardian Signature: _____ Date Signed: _____

I understand That I may revoke this authorization to release/request information at any time by giving written noticed to Beautiful Autism, LLC. Without such revocation, this authorization shall expire on _____/_____/_____ (Date). [If left blank, ninety (90) days from the date of my signature]. I also herewith release Beautiful Autism, LLC., from all liability for releasing such information.

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

I hereby revoke this Authorization to release/request information:

Client Signature: _____ Date: _____

Witness: _____Date: _____