Behavioral Solutions, LLC.
523 N Route 291
Liberty, MO 64068

Phone (816) 984-8290
Fax (816) 439-6169

Authorization to Release Confidential Record and Information

Student/ Customer Name: _____**DOB:** _____

Street Address: _____ **City/ State** _____ **ZIP:** _____

I understand this release is voluntary and applies to all programs and services operated under the auspices of BEHAVIORAL SOLUTIONS, LLC. I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. **I understand that I may revoke this authorization at any time by notifying BEHAVIORAL SOLUTIONS, LLC in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.**

I hereby authorize BEHAVIORAL SOLUTIONS, LLC to (check all that apply)

☐ Exchange with ☐ Release to ☐ Obtain from **the parties I have indicated below**

I hereby authorize BEHAVIORAL SOLUTIONS, LLC to exchange / release / obtain information:

☐ Verbally only ☐ In written form only ☐ Both verbally and in writing

Organization or Individual receiving/communicating the information:

_____

Name of organization/individual

_____

Address **City, State** **Zip** **Phone**

Description of Information to be exchanged / released / obtained:

☐Education Records ☐Medical records
☐Evaluation/assessment/eligibility records ☐ **other** _____
☐Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

Duration of release (check one) :

☐This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.
☐From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

The purpose if this release is: _____

_____

Signature of Student/ Consumer/ Patient or Legally Authorized Representative **Date**

_____

PRINT NAME and Relationship of Legally Authorized Representative to Student/ Consumer/ Patient

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