Authorization to Disclose Health and Educational Information

Name: _______________________ **Date of Birth:** _____________________________

Name: _______________________ **Date of Birth:** _____________________________

Name: _______________________ **Date of Birth:** _____________________________

1. I authorize the use or disclosure of the above named individual's educational and/or health information as described below for use by Slater & Associates, LLC to assist in the diagnosis and treatment of the named individual and/or the individual's family. I also authorize Slater & Associates, LLC to communicate relevant information obtained over the course of treatment/consultation to the individual, entity, institution and/or schools listed below.

2. Name of the individuals, entities, institutions and/or schools authorized to make the disclosure:

    1.____
    2.____
    3.____
    4.____
    5.____
    6.____

3. The type and amount of information to be used or disclosed is as follows:

□ All special education records
□ All school records (including attendance, faculty observations, anecdotal and/or counseling notes, and discipline records)
□ All medical records
□ All diagnostic and assessment information including psychological or psychiatric reports and evaluations
□ Results of Drug & Alcohol Testing
□ Laboratory results
□ All records as needed for assessment, treatment planning and coordination of services or other :
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4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Slater & Associates, LLC. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
____.

6. I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_______________________________________ _________________________
Signature of Client or Legal Representative Date

_____________________________________ _______________________
Signature of Client or Legal Representative Date