AUTHORIZATION TO DISCLOSE AND/OR EXCHANGE OF MEDICAL, BEHAVIORAL, EDUCATIONAL AND/OR OTHER PROTECTED HEALTH INFORMATION

Patient Name: ___________________________ Date of Birth: __________________

SPECIFY RECORDS, PERSONS, AND FACILITIES

➡ Check the box to choose the type of information to disclose.

➡ List the name, facility, and contact information to authorize for Bloom Behavioral Health's designated employees to exchange protected health information.

| | Medical Information: Diagnostic evaluation and summary, birth records, office visits, physical examination, developmental assessments, hospital admission and discharge summaries.

Physician Name & Hospital Name: ____

| | Educational Records: School assessments and Individualized Education Plan (IEP)

School Psychologist, Teacher, Behavior Analyst, Speech Pathologist, Occupational Therapist & Name of School & District:_______________________

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| | Psychiatric/Psychological Information: mental health evaluation and treatment records, psychological/ psychiatric diagnostic assessments including testing scores, medication information.

Psychologist and/or Psychiatrist Name & Facility Name: ____

| | Behavioral Health Information and/or Other Related Therapies: review of previous behavior service reports, assessment and progress reports from Speech Pathologist, Occupational Therapist, Physical Therapist, and/or related therapies.

Speech Pathologist, Occupational Therapist, Physical Therapist, Behavior Analyst & Facility Name(s): _________________________________

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| | Regional Center: developmental assessment, regional center documents, Individualized Program Plan (IPP)

Service Coordinator Name & Regional Center: ____

| | Insurance Health Plan: ________________________________ | | Other (specify) ________________________________

I hereby authorize the above named health plan, medical practitioner, hospital, clinic, mental health facility, regional center, school and/or its designated employees to exchange/receive the protected health information and/or educational records regarding the individual/patient indicated with Bloom Behavioral Health Inc. and/or its designated employees.

DURATION: The authorization shall become effective immediately and shall remain in effect until______________ (enter date) or for one year from the date of signature if no date is entered.

REVOCATION: This authorization may be revoked by the undersigned at any time. The revocation must be in writing, signed by the undersigned, and sent to Bloom Behavioral Health Inc. by fax (714) 716-4433 or email info@bloombh.com. Written revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.

REDISCLOSURE: Bloom Behavioral Health Inc. may not re-disclose the information obtained under this authorization unless additional authorization is obtained or disclosure is specifically required or permitted by law.

I request that the health information released pursuant to this authorization be used for the following purposes only: behavioral health treatment for autism. I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I have a right to receive a copy of this authorization for my records. A copy of this authorization is valid as an original.

Signature of patient or patient's legal representative____ Date_____________________________

Printed Name____________________________________ Relationship if signed by someone other than the patient__________________________