

# Guiding Exceptional Parents, LLC

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## Authorization Form for Release of Clinical Record

*This form when completed and signed by you, authorizes us to release protected information from your clinical record to/from the provider you designate below.*

|                     |  |
|---------------------|--|
| Provider Name:      |  |
| Position:           |  |
| Employer:           |  |
| Address:            |  |
| Phone Number(s):    |  |
| E-mail address(es): |  |

I authorize Guiding Exceptional Parents, LLC and its associates to exchange with each other any and all information, both oral and written, concerning the patient's history, condition and treatment for the purpose of coordinating and improving treatment. I authorize that this information exchange may continue for one year commencing from the date of my signature.

I understand that Guiding Exceptional Parents, LLC cannot re-disclose information she received from another provider if that provider requested that the information not be re-disclosed.

|                     |  |
|---------------------|--|
| Patient Name:       |  |
| Address:            |  |
| Phone Number(s):    |  |
| E-mail address(es): |  |

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Guiding Exceptional Parents, LLC. The revocation will not be effective to the extent that action has already been taken in reliance on *this* authorization. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and would thus no longer protected by the HIPAA Privacy Rule.

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Client or Guardian's Signature

Date