POSITIVE INTERVENTION PROBLEM SOLVING

Wendela Whitcomb Marsh, BCBA, LEP, RSD

RELEASE OF RECORDS / INFORMATION EXCHANGE AUTHORIZATION

If you would like Dr. Marsh to access records from other providers or entities, in order to inform and optimize the therapeutic relationship and increase understanding of previous services and supports, please fill out and sign this form.

Client's Name:	Date of Birth:
Parent (if minor):	Date of Release:

Information to be released:	☐ Treatment Summary ☐ Report ☐IEP ☐ Other:
Purpose of disclosure:	☐ Coordination of Care ☐ Other:
Who is authorized to release records:	
Who is authorized to receive records:	
Method of disclosure:	☐ Written ☐ Verbal/Telephone ☐ Electronic ☐ Any/All
Authorization to expire on:	(or 1 year after date signed)

I understand that health information is protected by law. I authorize the release of the confidential health information as indicated above. I understand that this consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of Adult Client: _____

Signature of Parent/Guardian of Minor Client:_____

Date Signed:_____