C. Saks Behavior Therapy Services

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby authorize C. Saks Behavior Therapy Services to disclose the following information from the health records of:

Name _____ Date of birth _____ ID No._N/a

Address _____ Telephone _____

covering the period(s) of health care

From (date) _____ to (date) _____

2. Information to be disclosed:

- ☐ Behavioral assessment ☐ discharge summary
- ☐ progress notes
- ☐ consultation reports
- ☐ behavioral support plans and quarterly reports
- ☐ treatment for alcohol and/or drug abuse
- ☐ other (please specify) _____

3.I understand that this will include information relating to acquired immunodeficiency syndrome (AIDS) and/or human immunodeficiency virus (HIV) ___NA_____ (initial)

4.This information is to be disclosed to _____ for the purpose of _____

_____

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____(initial)

6. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. _____(initial)

Signed:

Client Name	Signature	date

Legal Representative Name (date)	Signature	date

Name of witness	Signature	date