AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Client Name:	Client Date of Birth:
Parent/Guardian Name:	

I, the parent/guardian of the client named above, request that health information regarding my child's care and treatment be released for treatment planning and insurance billing as set forth on this form.

In accordance with the New York State Law and Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- This authorization includes disclosure of information relating to Applied Behavior Analysis treatment.

- I have the right to revoke this authorization at any time by contacting Life's WORC/The Family Center for Autism via email, phone call, or written communication. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

- Signing this form allows Life's WORC/The Family Center for Autism and/or Amvik Billing Solutions to utilize the following information:

    - Medical records
    - Session notes
    - Data/graphs
    - Billing records
    - Insurance records and card
    - Assessment/evaluation results

AUTHORIZATION TO DISCUSS HEALTH INFORMATION

By signing here, _____ I authorize Life's WORC/The Family
(Parent/Guardian Signature)
Center for Autism and Amvik Billing Solutions to discuss my health information with my health

insurance company.

Date signed: _____