Authorization for Medical Release of Information
From and To the Autism Allies, LLC

Patient Name ____ **Date of Birth** ________________

Address____ **City/State/Zip**____________________________

Phone ___________________________

Parent/Guardian/Requestor Completing This Form ____

RELEASE FROM and TO:

I authorize the following to release Medical Record information to Autism Allies, LLC:

Pediatrician/Family Doctor:

Name/Practice____

Address/City/State/Zip ____

Phone ________________________ Fax _____________________

Psychologist/Therapist/Other:

Name ____

Address/City/State/Zip ____

Phone ________________________ Fax _____________________

Individuals that I authorize to attend appointments with the patient when I am not available:

Name _____________________________ Relationship to patient_________________________

Name _____________________________ Relationship to patient_________________________

Name _____________________________ Relationship to patient_________________________

INFORMATION TO RELEASE

____ Complete Medical Record, including psychotherapy notes, substance use and HIV/AIDS related information

____ Medical Record for Dates: ________ to ________, including psychotherapy notes, substance use and HIV/AIDS related information

Important: If we are communicating with other caregivers, we will send the initial evaluation and last three visits unless you ask us to do otherwise. This is usually the most helpful format for other providers. Please show valid ID with your records request.

RELEASE MEDICAL INFORMATION FROM and TO:

Autism Allies, LLC
11154 Huron St #212
Northglenn, CO 80234
Phone: (303)355-5300
Fax: (303)452-4625

PATIENT/AUTHORIZED REPRESENTATIVE AUTHORIZATION

I understand that: (1) My signature on this form is strictly voluntary. (2) I may revoke this authorization at any time in writing, and if I do it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. (3) If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. (4) If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

Expiration: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 365 days from the date hereof.

______________________________ ______________________________ ______________

Signature Relationship to Patient Date