Sound Connections
COUNSELING & CONSULTING, LLC

REQUEST AND AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

Regarding:

Client Name:	**DOB:**

I hereby authorize *Sound Connections Counseling & Consulting, LLC* to obtain/share information with:

Person/Facility/School:				Fax:
Address:	City:	State:	Zip:	Phone:

The purpose of this authorization is:

☐	Assist with evaluation and facilitate intervention planning.
☐	Promote on-going communication for the continuity of care.
☐	Other:

The following information may be released from my records:

☐	Intake and discharge summaries	☐	Medical history and evaluations	☐	Psychiatric evaluations
☐	Psychological evaluations (incl. cognitive & educational)	☐	Educational records (IEPs, report cards, ISAT results)	☐	Development/social history
☐	Progress notes	☐	Neurological evaluations	☐	Treatment plans
☐	Verbal communication	☐	Other:		

I understand that my records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), state regulations, and professional ethics codes. They will not be disclosed without my written authorization, except as described in the HIPAA Notice. I also understand that I may revoke this authorization at any time except to the extent it already has been used. This authorization will be valid no longer than is reasonably necessary and shall not exceed 1 (one) year past the date of signing. This authorization is voluntary on my part and is not a condition of service or treatment.

____ _______________
Signature of Client (or Parent / Legal Guardian) Date

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Printed Name of Signer