EMBRACE
THE JOURNEYS

Authorization to Release/Obtain Confidential Information

Child's Name: _____ DOB: _____ Age: _____

I understand that my records and personal health or educational information are protected by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and/or FERPA (Family Educational Rights and Privacy Act - educational federal privacy law). Therefore, Embrace the Journey staff need to obtain my permission in writing before speaking to any other agencies or persons about me. This form allows Embrace the Journeys to receive and send information to the agency or persons below.

I authorize to release information to and obtain information from:

1._____ _____

Name of person(s) *Phone/email*

_____

Name and Address of agency

2._____ _____

Name of person(s) *Phone/email*

_____

Name and Address of agency

The type(s) of my information I authorize to be shared:

- ☐ Types of service, Dates of service, appointment dates
- ☐ Records, including:
  - o Evaluations/assessment
  - o Treatment plans and reports
  - o Individual Education Program (IEP)
- ☐ Verbal consultation to discuss summary of services/supports, referrals, and/or records
- ☐ Other: _____

The information may be released for the purpose of:

- ☐ Coordination of services
- ☐ Other: _____

This consent shall be valid until: ☐ 1 year from date of signature ☐ Other date: _____

I understand that this consent to release information can be revoked by me in writing at any time and from that point forward, no further information will be shared. You should understand that we will not be able to take back any disclosures we have already made with authorization

_____ _____ _____

Signature: Circle one: Client/Parent/Guardian *Printed name* *Date*

_____ _____ _____

Staff/ Embrace the Journeys/Witness Signature *Printed name* *Date*