Consent to Obtain Records/Information

Client's Name: ______________________________________ Date: _____________

I, (print name) ____________________________ give my consent for Boston Behavior Learning Centers (BBLC) to OBTAIN pertinent records (educational/medical/clinical/psychological) by mail, fax, email or verbally, pertaining to my child that will be helpful to my child's therapeutic needs from the provider identified below.

Provider authorized to release information to Boston Behavior Learning Centers:

Name:_________________________________

Provider Specialty:_____________________________________

Contact information: _______________________________________

Term: I understand that this authorization will remain in effect:

___From the date of this authorization until (date authorization to end)_______________________

___Until the Provider fulfills the request_________________________

___Until the following event occurs_____________________________

___No limitations on term of authorization

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality regulations. I understand that I have a right to revoke this authorization by submitting said revocation in writing to BBLC. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_______________________________________ ______________

Parent / Guardian Signature Date