Association of Behavior Consultants, Inc.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (ROI)

Section A.

Client Name _____ Date of Birth _____/_____/_____

Print Name of Person Authorizing Release _____

Relationship to Client _____ Phone _____-_____-_____

Address _____ City _____ Zip _____

Section B.

This release is for bi-directional release of patient information between the two agencies listed below:

Association of Behavior Consultants, Inc.
Managed Health Network, Inc. (Health Net, Inc.)

Section C.

The following information may be released between the two agencies listed above unless listed in box B:

Intake Records	Diagnostic Reports	Discharge Summaries
Consultation Reports	Behavior Assessments	Standardized Test Results
Billing/Financial information	Psycho-Social Reports	IEP, IPP, IEE, IFSP
Psycho-Educational Evaluation	Social History Reports	Progress Reports

Anecdotal information in the form of telephone conversations.

Other, SPECIFY: _____

Section D.

Use this field to list any information listed above that you **DO NOT** want released:

I can revoke this authorization at any time but information released prior to the revocation will not be affected. I understand that I can refuse to release any information and that such refusal will not have an impact on my care or treatment. A copy of this release will serve with the same effectiveness as the original. The HIPAA Privacy Rule regulates the use and disclosure of Protected Health Information (PHI) held by "covered entities" (generally, health care clearinghouses, employer sponsored health plans, health insurers, and medical service providers that engage in certain transactions.) By regulation, the Department of Health and Human Services extended the HIPAA privacy rule to independent contractors of covered entities who fit within the definition of "business associates" PHI is any information held by a covered entity which concerns health status, provision of health care, or payment for health care that can be linked to an individual. Covered entities must disclose PHI to the individual within 30 days upon request.

This release of information is authorized effective: _____/_____/_____ and will expire after one year unless indicated here: _____/_____/_____.

Print Name of Person Authorizing Release of Information _____

Signature _____ Date _____/_____/_____