Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Patient/Guardian Authorization

You may use or disclose the following health information:

☐ All my health information including but not limited to AIDS/HIV and other Communicable disease information, Behavioral Health Care/ Psychiatric Care, Alcohol and/or drug abuse treatment, if any unless specifically excepted: _____.

☐ Comprehensive Diagnostic Evaluations or other Behavioral Health Diagnostic Tools

☐ Other: _____

You may disclose this health information to:

Name: Marcus Hibbard BCBA, LBA & Andrew Chism, MBA

Company: Therapy Dads, LLC d/b/a Bright Futures ABA

Address: 710 Clayworth Drive. Ballwin, Mo 63011

Phone: 314.390.6923 Fax: NA

Do you want us to ☐*Fax or* ☐ *mail your child's medical records?*

Authorization Agreement (Initial Below)

_____This authorization is valid for six (6) months from the date of signing and may be revoked at any time by providing a written notice of revocation.

_____I understand that I cannot revoke this authorization retroactively for information already released.

Patient or legally authorized individual signature	**Date**
Printed name if signed on behalf of the patient	**Relationship (parent/legal guardian)**