Cornerstone
BEHAVIORAL SERVICES

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the supervision of Cornerstone Behavioral Services, LLC.

I hereby authorize Cornerstone Behavioral Services, LLC to (check all that apply):
____ Exchange information with
____ Release information to
____ Obtain information from

The following Organization/Individual in regard to the above named patient:
Name of Organization/Individual: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

I hereby authorize this information to be exchanged in the following manner(s):
____ Verbal only
____ Written form only
____ Both verbal and written communication

Description of information to be exchanged / released / obtained (select all that apply):
____ Education records
____ Evaluation/assessment/eligibility records
____ Medical records
____ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)
Other: _____

This information is to be used for diagnostic, treatment planning and continuity of care purposes only.

This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.

From _____(MM/DD/YYYY) To _____MM/DD/YYYY)

_____ _____
Parent/Guardian Printed Name Date

_____
Parent/Guardian Signature

Records Released by: _____ Date: Released: _____