AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____ DOB: _____

I, _____ (Client or legal guardian), hereby authorize

Mandala Family Wellness LLC to ☐ end and/or ☐ eceive information (as noted below) ☐ and/or ☐ om

Name of Person or Facility: Keystone Behavioral Pediatrics Phone: 904.619.6071 Fax: 904.212.0309 _____

Address: 6867 Southpoint Dr N City: Jacksonville State: FL Zip: 32216

_____ Academic Testing Results

_____ Behavior Programs

_____ Progress Notes

_____ Cognitive Testing Results

_____ Medical Records

_____ Personality Profiles

_____ Psychological Reports

_____ Psychological Testing Results

_____ Service Plans

_____ Summary Reports

_____ Vocational Testing Results

_____ School Records

_____ Entire Record (*except psychotherapy notes)

*Psychotherapy notes have increased protection under HIPPA, a separate authorization is required

The above information will be used for the following purposes:

_____ Planning appropriate treatment or program

_____ Continuing appropriate treatment or program

_____ Determining eligibility for benefits or program

_____ Case review

_____ Updating files

I understand that this information may be protected by title 42 (Code of Federal Rules of Privacy or Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality or Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke the consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have the right to refuse to sign this authorization.

Patient Signature (if over 18 years or emancipated): _____ Date: _____

For Minors:

Legal Guardian Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____