THE spectrum CENTER LLC.

Testing and Counseling services for the autism, gender, ADHD and learning diversity spectrums
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Patient Name: _____ DoB: ____/____/____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

The Spectrum Center is authorized to: _____ Receive and/or _____Release

Information to/from:

Person:_____

Facility: _____ Fax: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

What information will be released?

_____ Psychiatric evaluation and treatment
_____ Psychological evaluations and therapy
_____Drug and/or alcohol treatment and testing
_____ Educational records
_____ Medical records
_____ HIV information
_____ Other: _____

Purpose for sharing the information: _____

Expiration: My permission will expire one year after the date of signature unless an earlier date is indicated

Expiration date: ____/____/____

Understanding the authorization:

- This allows the release or obtaining of information that exists in the patient's records when the form is signed, as well as information created after the form is signed until it expires.
- I may withdraw my permission at any time by providing written notice to The Spectrum Center. For information being released by The Spectrum Center and how to withdraw (revoke) authorization, see its *Notice of Privacy Practices*. If I withdraw my permission, any information that was already released cannot be retrieved.
- Information released by The Spectrum Center may be released again by the person or organization that receives it and is no longer protected under federal privacy laws. The Spectrum Center will protect information it obtains as required by federal privacy laws.

Signature. By signing, I understand that I am authorizing The Spectrum Center to release/obtain information as described above**.**

_____ _____ _____
Signature Printed Name Date

Relationship to patient: [ ] Self [ ] Parent [ ] Legal Guardian Other: _____

_____ _____ _____
Teen signature if older than 14 yrs Printed Name Date