Release of Information Consent Form

Learning Coach LLC | Phone: (360) 207-4560 | Fax: (360) 325-7720 | www.LearningCoachWA.com

Medical Release of Information

For the purposes of evaluation and treatment planning,

1. **This form authorizes medical release of information regarding:**

   Client name_____ Date of Birth_____

2. **Learning Coach LLC is authorized to:**

   _____Send _____Receive

3. **The following information:**

   _____Medical history and evaluation(s)

   _____Mental health evaluations

   _____Developmental and/or social history

   _____Progress notes, and treatment or closing summary

   _____Other_____

4. **To / From**

   Physician / Pediatrician / Practice Name_____

   Address:_____

   Office Phone_____Fax_____

5. **Authorized by**

   Client or Legal Representative_____

   Relationship to client_____

   Signature_____Date_____

Educational Release of Information:

1. **This form authorizes educational release of information regarding:**

   Client name_____ Date of Birth_____

2. **Learning Coach LLC is authorized to:**

   _____Send _____Receive

3. **The following information:**

   _____Educational records

   _____Therapeutic history and evaluation(s)

   _____Therapeutic progress notes, and treatment or closing summary

   _____Other_____

4. **To / From**

   School Name_____

   Address:_____

   Office Phone_____Fax_____

5. **For the purposes of:**

   _____Evaluation and treatment planning

   _____Consultation

   _____Other_____

6. **Authorized by**

   Legal Representative_____

   Relationship to client_____

   Signature_____Date_____

Client Acknowledgement

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164), plus applicable state laws. I further understand that 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 this consent at any time by providing written notice, and after (some states vary, usually 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 a right to refuse to sign this authorization.

Client name_____Date of Birth_____

Legal guardian name_____Relationship to client_____

Signature_____ Date_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.