

# McClure, Mallory & Baron

EDUCATIONAL COUNSELING AND PLANNING

## AUTHORIZATION FORM

This form, when completed and signed, authorizes McClure, Mallory & Baron to release and/or receive protected information from your/your child's clinical records to/from the person(s) you designate.

I authorize McClure, Mallory & Baron to release and/or receive the following:

- Academic Records                       Assessment Reports                       Other (please specify)  
 Assessment Scores                       Diagnosis    \_\_\_\_\_

The above information is to be released for the purpose of:

- At the request of the individual                       Assessment  
 Treatment planning                                       Discussion  
 Educational consulting                                       Other (please specify) \_\_\_\_\_

From (Person/Organization making disclosure):

\_\_\_\_\_  
\_\_\_\_\_

To include (Person/Organization receiving disclosure):

\_\_\_\_\_  
\_\_\_\_\_

This authorization shall remain in effect until one (1) year from this date.

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation to McClure, Mallory & Baron's office address. I also understand that my revocation or modification will not be effective until McClure, Mallory & Baron receives it and I understand that I cannot do anything about information already used or disclosed under this authorization.

I understand that McClure, Mallory & Baron may not condition services upon my signing an authorization. Also, while the services provided by McClure, Mallory & Baron are generally not covered by insurance companies, I understand that my insurance company may not condition payment, enrollment, or eligibility for benefits upon my signing an authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and may no longer be protected by privacy laws. I hereby release McClure, Mallory & Baron from all legal responsibilities or liability that may arise from the use of disclosure of medical records and other health information in reliance on this authorization.

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Authorized Party (Print Name)

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Signature of Authorized Party

\_\_\_\_\_  
Date