# AUTHORIZATION FORM

This form, when completed and signed, authorizes McClure, Mallory, Baron & Ross 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 & Ross to release and/or receive the following:

- ❑ Academic Records
- ❑ Assessment Scores
- ❑ Assessment Reports
- ❑ Diagnosis
- ❑ Other (please specify) ____________________

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

- ❑ At the request of the individual
- ❑ Treatment planning
- ❑ Educational consulting
- ❑ Assessment
- ❑ Discussion
- ❑ 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 & Ross's office address. I also understand that my revocation or modification will not be effective until McClure, Mallory, Baron & Ross 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 & Ross may not condition services upon my signing an authorization. Also, while the services provided by McClure, Mallory, Baron & Ross 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 & Ross 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