



AUTHORIZATION TO RELEASE INFORMATION

I hereby give my consent for Graham Behavior Services, LLC (GBS) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Graham Behavior Services, LLC Notice of Privacy Practices provides a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. GBS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to GBS.

With my consent, GBS may mail to my home or other designated location and leave a message on voicemail or in person reference to any items that assist the practice in carrying out TPO, such as therapy reminders, insurance items, and any call pertaining to my clinical care, including assessment results among others.

With my consent, GBS may email to me therapy and patient statements. I have the right to request that GBS restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to GBS use and disclosure of my PHI to carry out TPO. A copy of GBS's Notice of Privacy Practices will be provided upon my request.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, GBS may decline to provide treatment to me.

I do not give consent for GBS to share treatment plan information with my child's diagnosing physician.

I give consent for GBS to share treatment planning information with my child's diagnosing physician.

Physician Name	Address	Phone

Signature of Parent/Guardian	Printed Name	Date Signed

Child/Client Name	
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