Authorization for Release of Information/Coordination of Care

In an effort to provide the best patient care possible, the Center for Autism and Related Services (C.A.R.S.), is required to initiate and maintain contact with other behavioral health providers or consultants and health care institutions where appropriate. Communication between C.A.R.S. Providers and institutions providing care to patient is important to ensure that the patient receives comprehensive and quality behavioral health care. This form will allow C.A.R.S. to share and request Protected Health Information (PHI) with these institutions. This information will not be released or obtained without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

PCP/Medical Clinician or Other Behavioral Health Clinician/Facility/School Information:

☐ All institutions ☐ Only those listed below

Name	Name
Street Address	Street Address
Address (City, State, Zip)	Address (City, State, Zip)
Telephone Number	Telephone Number
Company Title	Company Title

Patient Clinical Information

☐ All clinical records	☐ Referrals	☐ IPP
☐ Diagnosis	☐ Medications	☐ _____
☐ Treatment plan	☐ IEP	☐ _____

Limit to the following information: _____

I, the undersigned, understand that coordination of care is required by my insurance plan and I therefore, authorize C.A.R.S. to share and request information pertinent to the provision of ABA services for (patient) _____. I further understand that I may revoke this consent at any time through a written request.

Signature

Name

Date