**Authorization to Release Professional Information**

|  |  |
| --- | --- |
| **Child’s Name:** | **D.O.B.:** |
| **Person Completing Form:** | **Relationship:** |

I hereby authorize B.E.S.T. ABA to communicate with:

|  |
| --- |
| **Organization/person:** |
| **Contact Information:** |

B.E.S.T. ABA is authorized to communicate with the parties listed above in the following manner:

* Ongoing exchange for the duration of the terms of this release
* Release information to
* Obtain information from

Any information released or exchanged may not be disclosed to any other agency except those required by law. The following information is included in this release:

|  |  |
| --- | --- |
| * Evaluation Findings * Social History * Discharge Summary * Individualized Education Plan | * Diagnostic Information * Treatment Plan & Reviews * Test Results: Physical Exam/Audiology/Visual * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

This information may be transmitted: \_\_\_\_ by mail \_\_\_\_ by fax \_\_\_\_ by phone \_\_\_\_ by e-mail

**This consent automatically expires 1 year from the signed date below, or 30 days after termination of services (whichever comes first).**

Parent/Guardian Signature Date

B.E.S.T. Service Provider Signature Date