Social and Cognitive Learning Center

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize Provider: Social and Cognitive Learning Center to disclose information and records obtained in the course of the services provided {Name of child, if minor}_____ to _____.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 907 3rd Street Davis, CA 95616 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

_____.

The specific uses and limitations of the types of medical information to be discussed are as follows (be as specific as you choose to):

_____

_____

Such disclosure shall be limited to the following specific types of information:

_____

_____

Client/Parent understands that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule, although applicable California law may protect such information.

This authorization shall remain valid until: _____

Client's signature: _____ Date: _____

Parent's signature (if client is minor): _____ Date: _____