Florida Institute of Technology
The Scott Center
for Autism Treatment

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Client Name ____ Date of Birth ____________
Last *First* *Middle Initial*

I hereby authorize The Scott Center for Autism Treatment to provide documentation and collaborate with the following:

Name of Provider, Facility or Person ____

Street Address ____

City ______________________________ State ____________ ZIP ______________

Phone Number ______________________ Fax Number ______________________

In regards to the following information (sign your initials):

_____ Diagnostic Report(s)

_____ Assessment Report(s)

_____ Treatment Note(s)

_____ Other ____

Dates of Services: From ______________________ To______________________

This Authorization will expire in one year from the date signed. I hereby release The Scott Center, its employees, vendors and/or independent contractors from any and all liability that may arise from the release of this information as I have directed.

I understand that The Scott Center does not release medical records received from other physicians, facilities or hospitals. You must request these parties to send your medical records where you want them to go.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to The Scott Center for Autism Treatment.

I understand that the revocation will not apply to any information that has already been released in response to this authorization.

I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Legal Guardian ______________________________________ Date________________

Relationship to Client____

USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT

Signature of Legal Guardian ______________________________________ Date________________

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