Learning & Behavior Solutions, Inc.

1022 Jones Rd Ste 2, AR 72762
Phone: 479-318-2300 Fax: 479-763-0059
www.learningandbehavior.org
info@learningandbehavior.org

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ **Birthdate:** _____ **Parent/Guardian Name(s):** _____

Phone: _____ **Address:** _____ **City:** _____ **State:** _____ **Zip:**

I understand this release is voluntary and applies to all programs and services operated under the auspices of Learning & Behavior Solutions, Inc. I understand that my personally identifiable information (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. ***I understand that I may revoke this authorization at any time by notifying Learning & Behavior Solutions, Inc., in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.***

I hereby authorize *Learning & Behavior Solutions, Inc.* to *the parties I have indicated below* (check all that apply):

❒ Exchange with ❒ Release to ❒ Obtain from

I hereby authorize *Learning & Behavior Solutions, Inc.* to exchange / release / obtain information:

❒ Verbally only ❒ In written form only ❒ Both verbally and in writing

As parent or legal representative of the above-named client, **I request that information be released from:**

Name of Facility: _____

Phone: _____ **Fax:** _____ **Email:** _____

To the Attention of: _____

Address: _____

City, State, Zip: _____

To the following:

Name of Facility or Person: *Learning & Behavior Solutions, Inc.*

Phone: *479-318-2300* **Fax:** *479-763-0059* **Email:** tmrla@learningandbehavior.org

To the Attention of: *Tiffany Mrla, PhD, BCBA*

Address: *1022 Jones Rd Ste 2*

City, State, Zip: *Springdale, AR 72762*

Information Requested: _____

_____

Purpose of the requested information: _____

I understand the purpose for which this information is being requested. I also understand that a copy of this request is valid in lieu of the original. This request will expire one year form the date signed. I understand that I have the right to revoke the authorization, in writing, before the expiration date.

Parent/Legal Representative Name: _____ **Relationship to Client:** _____

Parent/Legal Representative Signature: _____ **Date:** _____

BACB Contact Information:
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***Alison Karnes*, PhD, BCBA**
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