BODIN

Mailing address only: 750 Alma Lane #100, Box 8207, Foster City, CA 94404

Phone: 650-937-1111 Fax: 650-937-0011

RELEASE FORM: AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

This form, when completed and signed by you, a client of BODIN or his/her legal representative, authorizes Bodin, and/or its clinical and administrative staff, to exchange with, release to, and/or receive from information of your record with/to/from the person(s) you designate, pursuant to the conditions specified below, and in accordance with governing statutes and regulations.

Name: _____ **DOB:** _____

is currently utilizing services of BODIN. In addition to VERBAL exchange, the records covered by this authorization include:

☐ Transcripts/Grade Reports	☐ Psychological Assessment/Reports
☐ School Counseling Records	☐ Treatment Records (medical, mental health, substance abuse)
☐ Court Documents; Attorney's Records	X Other: VERBAL

I give my permission for the information specified above to be:

- ☐ **Exchanged between** BODIN and the party named below
- ☐ **Released to BODIN** from the party named below
- ☐ **Released from BODIN** to the party named below

Records to be exchanged with:

Name or function of person(s): _____

Organization: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

I am authorizing BODIN to release, request or exchange this information as specified for the following purpose/s:

☐ Educational placement ☐ Psychological evaluation ☐ At request of individuals

☐ Other: _____

This authorization is subject to the following conditions:

This authorization shall remain in effect until _____ or one year.

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to BODIN. However, my revocation or modification will not be effective until BODIN receives it.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

_____ _____

Signature of Client/Parent/Guardian Date

_____ _____

Signature of Client/Parent/Guardian Date

_____ _____

Printed Name Relationship of Authorizing Party to Minor

_____ _____

Printed Name Relationship of Authorizing Party to Minor