AUTHORIZATION TO RELEASE/EXCHANGE

Consumer Information

Consumer Name*:

_____

Last_____First_____ MI_____

Address: _____

Date of Birth*: _____/_____/_____

City:_____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Other: (_____) _____ - _____

Agency Name/or Professional Authorized to Release/Exchange Info

Name*: _____

Agency: _____

Last_____First_____

Address: _____ City:_____

State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Other: (_____) _____ - _____

Email:

_____

I hereby (*please initial only one*): This authorization expires (6 months from date of signature, unless otherwise noted):

_____**DO** authorize the exchange, mutual use, and disclosure of information indicated below, for the specified purpose, between Boundless and the agencies/professionals above for the time frame checked below. You, as the consumer, have the right to shorten or lengthen this authorization period, as well as revoke the authorization at any time.

☐ **Single Use** ☐ **6 months** ☐ **1 Year**

_____**DO NOT** authorize the exchange, mutual use, and disclosure of information indicated above, for the specified purpose, between SBS and the agencies/professionals above.

I hereby authorize Step By Step (SBS) to (*please initial*): _____ Release To _____ Obtain From

I hereby authorize SBS to Release to/Exchange with/Obtain from (*please initial*):

_____ Verbally _____ Written _____ Electronically (e-mail)

For the purpose of (*please initial*):

_____ Establish Services _____ Assessment and Diagnosis _____ Continuation of treatment

_____ Other: Please Specify

_____

Specific information to be disclosed included (please initial):

boundless™
inspiring the potential of people

445 E. Dublin-Granville Rd., Worthington, OH, 43085
(614) 436-7837 Fax: (614) 436-8704
www.iamboundless.org

AUTHORIZATION TO RELEASE/EXCHANGE

_____Any and all documentation by Boundless staff

Treatment
_____Treatment Plan(s)/Reviews
_____Progress Notes/Progress Reports
_____Individual Service Plan (ISP) and Reviews
_____Mental Health Assessment (MHA) and Updates
_____Consumer Information Sheet

_____Behavior Plans
_____ABLLS/VB-MAPP Grid and Report
_____Medical Forms
_____Psychological Evaluation Reports
_____Psychiatry Reports

_____Other: Please Specify
_____

Educational
_____ Autism Scholarship Program Approval
_____ Individualized Education Plan (IEP)
_____ Evaluation Team Report (ETR)/MFE
_____ Progress Reports
_____ Other: Please Specify _____

Services
_____ Speech Evaluation and Reports
_____ Occupational Therapy Evaluations
_____ Physical Therapy Evaluations and Reports
_____ Other: Please Specify_____

_____	_____	_____
Consumer Print Name	Signature	Date
_____	_____	_____
Parent/Guardian Print Name (if applicable)	Signature	Date

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