RELEASE OF INFORMATION
Between Academy for Precision Learning and The Roots Clinic

Client/Patient Name _____ Date of Birth _____ /_____ /_____

Address_____

City_____State _____ Zip _____

Parent /Guardian Name: _____Phone:_____

Information to be released and/or received by: the Counseling Department at The Academy for Precision Learning 5031 University Way NE, Seattle, WA 98105 - Telephone: 206-427-0115- Fax: 206-331-3956

☒ May RELEASE & RECEIVE information to/from:

Name of Agency/Person: *The Roots Clinic at APL*

Relationship: *School-based ABA Provider*

Address: *5031 University Way NE, Seattle, WA 98105*

Phone: *206-427-0115*

☒ **All Health information about the patient/client, including my clinical records, created or received by the Provider.**
○

The purpose of the information being disclosed is to: Support Comprehensive Clinical and Academic Services

This authorization expires: OR ○ at the end of the current School Year _____
○ While enrolled at The Academy for Precision Learning

I understand that my records are protected under federal regulations governing confidentiality, including 42 CFR Part 2 laws regarding substance abuse treatment records that may be received by the Roots Clinic and the Health Insurance Portability and Accountability Act of 1996 [HIPAA], and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that without this authorization, my services will not be denied, yet, could hamper the effectiveness of the services. Services are not determined on whether or not the ROI is signed. I have read and understand the terms of this Authorization. I understand I am entitled to a copy of this Authorization after I sign it.

Parent/Guardian Signature: _____ Date: _____ /_____ /_____

Patient / Client Signature: _____ Date: _____ /_____ /_____

Printed Name: _____