The Craig School

TEACHING THAT TRANSFORMS™

Authorization to Release or Share information

Client Information:	Name: _____ Address: _____ Date of Birth: ___ / ___ /___ Phone: _ _ _-_ _ _- _ _ _ _
Record Holder: Who has the information you want to release?	The Craig School 3400 Michelson Dr. Suite 200 Irvine, CA 92612
Release Records to: Where do you want records sent? Who do you want to receive records?	Name: _____ Address: _____ Phone: _ _ _-_ _ _- _ _ _ _ Fax: _ _ _-_ _ _- _ _ _ _
Purpose: Check box that applies.	☐ Continued Care ☐ Legal ☐ Personal ☐ Disability ☐ Other_____
Information to be released: What do you want sent or released? Check box that applies and specify added information if necessary	☐ IEP ☐ Diagnostic Report/information _____ ☐ Academic Report/information _____ ☐ 504 Plan ☐ Behavioral Health information _____ ☐ Other_____
Sensitive information:	☐ Mental Health/Psychiatric treatment records _____
Authorization	I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) Conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party. I understand this authorization may be revoked in writing at any time except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked this authorization will expire 12 months after the date of signing this form.
Authorization Signature:	Signature of client or authorized representative: _____ Printed Name: _____ Date: ____/____/____ Time: _____AM/PM Relationship (if signed by other than Patient) _____ If interpreted: Signature OR ID of Interpreter _____ Language: _____ Date: ___/___/___ Telephone or Video _____

To protect our client's confidential information, we must have a valid, complete, and legible authorization to disclose their health information.
All sections of this authorization must be filled out before The Craig School is permitted to disclose your protected information.
Notice: The Craig School and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your protected health or academic information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. Revocation: A revocation/cancellation of this authorization can be provided at any time in writing to: The Craig School, Inc., 3400 Michelson Dr., Suite 200, and Irvine, CA 92612

STAFF USE ONLY	Information Released by: _____On Date: ____/____/____