



"Unlocking Your Child's Journey to Independence"™

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AUTHORIZATION FOR MUTUAL DISCLOSURE/RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____ SSN: _____

I authorize information to be **exchanged** between **Dower and Associates, Inc.** and

(Name of Authorized Organization/individual to whom disclosure is made) (Address &/or Phone)

The reason for this disclosure is:

- Coordination of treatment services
- Aftercare Planning
- Satisfy Legal Requirements
- Family Support/Involvement
- Billing/ Payment of Bill
- Other: _____

The **specific information to be disclosed** is: (check each specific item to be disclosed)

<input type="checkbox"/> Speech/Language, Educational and Behavioral Assessments ; IEPs and IFSPs	<input type="checkbox"/> Lab/Diagnostic/TB tests/ Drug & alcohol testing results
<input type="checkbox"/> Recommendations/ Prognoses	<input type="checkbox"/> Treatment Plans/Treatment Summaries/Treatment Dates
<input type="checkbox"/> Legal History/ Probation/ Parole Information	<input type="checkbox"/> Discharge Summary/ Continuing Care Plan
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Psychological testing/assessment reports
<input type="checkbox"/> Medical History and Physical and Prior diagnosis	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____



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* Speech/Language Evaluations and Therapy * Academic & Remedial Tutoring * Educational Consultations * IEP Development & Consultations *
* Autism Home/School Programs- Specialty: Applied Behavior Analysis (ABA) with Verbal Behavior Emphasis *

Release of Information/Disclosure
Revised April 2008

I understand that the above checked items may include information regarding behavioral health treatment (mental health and/or substance abuse) that I may have received.

Amount of information to be disclosed:

- information covering all previous and current admission
- information covering current admission only
- information covering the previous 3 months
- information covering specific dates: _____

This release will expire:

- 3 months
- 6 months
- 12 months
- other: _____ days/months after the date signed.

OR

- The specific date or event/condition upon which this consent will expire is _____.

OR

- The formal and effective termination or revocation of my probation, or parole, or other proceeding under which I was mandated into treatment (for court mandated substance abuse/dependency treatment)

The information released is for professional purposes only. Only the minimum amount of information needed to achieve the purpose may be disclosed. It may not be provided in whole or part to any other agency, organization or person, other than that which is stated above. I have read and agree that all information was properly completed prior to my signing this form, understand that this form is not required as a condition for treatment, and have the right to access the information to be disclosed. I have the right to shorten or lengthen the authorization period at any time. This authorization **is subject to revocation at any time** except to the extent that Dower and Associates, Inc. has already acted in reliance on it. The revocation must be in writing. I understand that Dower and Associates, Inc. cannot guarantee that the Recipient will not disclose my health information to a third party and the Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about alcohol or drug abuse treatment, the Recipient is prohibited from re-disclosure under federal law (42 CFR, Part 2) See notice below.

(Client Signature) (date)

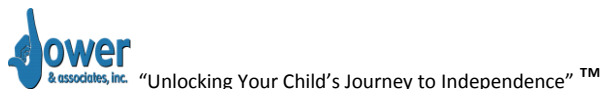
(Parent / Guardian/Authorized Personal Representative **Signature**) (date)

(Witness) (date)

(Parent / Guardian/Authorized Personal Representative **Printed Name**)

Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by Federal Confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

<p>Renewal of Expired Authorization: This authorization is renewed effective _____. The new expiration date is _____. Signature: _____ Witness: _____</p>	<p>Revoked Authorization: Client/ Guardian has revoked this authorization as of _____ (date). Signature: _____ Witness: _____</p>
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