**Milestones in the Making**

YMT & Associates, Inc.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**AUTHORIZATION TO RELEASE/RECEIVE CLIENT INFORMATION**

**(YOU ONLY NEED TO COMPLETE THIS IF YOU WOULD LIKE TO GIVE PERMISSION TO MS. TAMAYO AND ASSOCIATES TO SPEAK WITH A TEACHER, DOCTOR, ETC., OR SEND A COPY OF THE EVALUATION REPORT TO A PARTY YOU SPECIFY ON THE FORM) (Fax# 352-374-7195)**

I hereby consent for Milestones in the Making, YMT & Associates, Inc. to release/receive pertinent information regarding the following client:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s Full Name Date of Birth**

**To/from the following person or agency:**

Agency Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information Type:** The following checked items are being: Released\_\_\_\_ Requested\_\_\_\_

\_\_Assessment \_\_Psychological Evaluations \_\_Continuing Care Plan

\_\_Diagnosis \_\_Medication Management Info. \_\_Discharge/Transfer Summary

\_\_Treatment Plan/Summary \_\_Demographic Information \_\_Legal/Criminal Justice Info.

\_\_Medical Information \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this authorization is subject to revocation at any time, except to the extent that Milestones in the Making, YMT & Associates, Inc. has already taken action on this authorization. If not revoked earlier by written notice to Milestones in the Making, this authorization will expire as follows:

**Check one:**\_\_\_\_One year from date of signature below

\_\_\_\_Upon reaching (Specific date, event or condition)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Once the requested information is disclosed pursuant to this authorization, Milestones in the Making will no longer have control over the information, and there is a potential that it may be re-discolsed by the recepient and will no longer be protected by the privacy under the Health Insurance Portability and Accountability Act (HIPPA).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date Client Signature(if applicable)