Milestones in the Making

YMT & Associates, Inc.

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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 #: ____________________________

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Fax #:__________________________________

Agency Name:____________________________ Contact Person:________________________

Address:________________________________ Phone #: ____________________________

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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)