Great Lakes Center for
Autism Treatment
and Research
an roi program

Great Lakes Center for Autism Treatment and Research
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____
Last Name First Date of Birth

Clearly Circle "Yes" or "No." Note that "Yes" ONLY refers to the items that this authorization for use/disclosure/exchange of information applies to, as this authorization for use/disclosure/ exchange of information is limited to the extent and nature of information identified below.

Person(S), class of person(S) and/or entities whom I have authorized to request, receive and use confidential/protected information about me.	Medical Records Summary, (Including information related to psychiatric or mental health treatments)	Social History Summary	Educational Records (Including IEPs & psychological evaluations)	Psychological/Diagnostic Report	Assessment Report	Treatment Plans & Progress Reports	Occupational/Physical/ Speech Therapy Report	Other:	Other:
Community Mental Health Agency:	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
School:	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
ISD:	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Primary Care Provider:	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Other:	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Other:	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Other:	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

This statement of consent can be revoked at any time before disclosure of the information, and expires, in any event, 12 months after it is signed.
Authorized by:

____ __________
PARENT/GUARDIAN SIGNATURE DATE

____ __________
WITNESS DATE