Stepping Stones ABA
4929 Darcy Woods Ln. Fuquay Varina NC 27526
Phone: 919-810-1459 Fax 919-400-4224
Rebecca@steppingstonesaba.com

Release of Client Records

Client Name: _____ **DOB: _____**

Client 18+: YES / NO **If yes, "Client Request Release of Records will be Required**

Date of Request: _____ **Request Made by: _____**

Relationship to Client: _____ **Date Processed: _____**

I, the undersigned, can verify I am the legal guardian/parent of the abovementioned client. I authorize the release of, or request access to the information specified below from the medical record(s) of the above mentioned client.

CLIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Personal Use	Social Security/Disability
Insurance	Military	Other: _____
Legal Purposes	School	

INFORMATION TO BE RELEASED OR ACCESSED:

Treatment Plan(s)	Consent/HR Form(s)	Supervisor: _____
Behavior Services Contract	Treatment Overview/Report	

The above information will be released to:

FULL NAME DATE

I understand the medical records released are confidential. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include by is not limited to: history, medical diagnoses, and treatment outcomes as it pertains to past and present symptoms related to treatable medical diagnoses within this profession.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Method of Record Delivery: _____

Signature: _____ Signature: _____
Parent/Legal Guardian SSABA Mgmt.