CBL
CENTER FOR
BEHAVIOR
AND LEARNING

RELEASE OF INFORMATION

Fax: (952) 213-6116
www.centerforbehaviorandlearning.com

Child's Name	Child's Date of Birth

Check all that apply:

☐ I authorize _____ to release my documents to the contact/organization below.
(CBL Provider Name)

☐ I authorize the contact/organization below to release copies of my documents to _____.
(CBL Provider Name)

☐ I authorize _____ to communicate verbally with the contact/organization below.
(CBL Provider Name)

Complete this section to authorize the release of information to/from this contact/organization.

Contact Name	Clinic/Organization Name	Phone
Address	City/State/Zip Code	Fax

Specific dates of service or range of dates of service to be released:_____(or specify below in box)

Information to be released:

☐ School Cumulative Records; to include standardized testing results, report cards, documentation of behavior difficulty, documentation of child study team, other academic records	☐ School SPED/ECSE and related services records; to include evaluation reports, IEP/504 Plan, rehab records, guidance counseling records, gifted and talented assessment results	☐ Mental Health Records (circle all that apply): Intake Report / Treatment Plan / Therapy Notes / Discharge Summary
☐ Rehabilitation Evaluations/Reports: Specify): PT / OT / Speech Therapy	☐ Radiology Reports (x-ray, MRI, CT, etc.)	☐ Genetic Testing
☐ Psychological Evaluation/Testing	☐ Chemical Dependency Records	☐ Laboratory/Pathology Reports ☐
☐ Medication Lists	☐ Clinic Visit/Consultation/Discharge Notes	☐ Other

Reason for release (circle all that apply): continued care insurance litigation personal consult/second opinion

Other (please specify:_____

I understand that: I make revoke this authorization at any time by **WRITTEN REQUEST**. Revoking authorization will NOT apply to information already released in response to this authorization. A photocopy or facsimile of this authorization will be treated in same manner as if it were the original form. Once information is released because of this authorization, the CBL Provider cannot prevent re-disclosure of the information by a third party. I understand I need not sign this form in order to assure treatment. **This authorization expires one year from the date signed. I understand that may be a charge for my records per Minnesota Statute 144.335.**

_____ _____ _____
Signature of client/parent/guardian Relationship to client Date