Spectrum Services
5501 Fortunes Ridge Drive, Suite H
Durham, NC 27713
Fax: 919-213-9845
www.spectrumservices.org

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ DOB: _____

I understand this release is voluntary and applies to all programs and services operated under the auspices of Aurelie Welterlin, PLLC. I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. **I understand that I may revoke this authorization at any time by notifying Katherine Okoniewski, M.Ed, LPA in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.**

I hereby authorize Katherine Okoniewski, M.Ed, LPA to (check all that apply):
❒ Exchange with ❒ Release to ❒ Obtain from the parties indicated below

I hereby authorize Katherine Okoniewski, M.Ed, LPA to exchange/release/obtain information:
❒ Verbally only ❒ In written form only ❒ Both verbally and in writing

Organization or Individual receiving/communicating the information:

_____
Name of Organization/Individual

_____
Address City, State, Zip Phone

Description of information to be exchanged/released/obtained:
❒ Education records ❒ Medical records
❒ Evaluation/assessment/eligibility records ❒ Other _____
❒ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)

Duration of release (check one):
❒ This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.
❒ From _____/_____/_____ to _____/_____/_____

Purpose of Release: _____

_____
Signature of Client or Legally Authorized Representative Date

_____
PRINT NAME and Relationship of Legally Authorized Representative to Client