Nash Therapeutic Services, LLC

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Suite 100
N. Little Rock, AR. 72114

AUTHORIZATION TO RELEASE INFORMATION

Student/Consumer Name: _____ **DOB:** _____

Street Address: _____ **City/State** _____ **ZIP** _____

I understand this release is voluntary and applies to all programs and services operated under the auspices of Nash Therapeutic Services. 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 Nash Therapeutic Services in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.**

I hereby authorize NASH THERAPEUTIC SERVICES to (check all that apply):
❒ Exchange with ❒ Release to ❒ Obtain from **the parties I have indicated below**

I hereby authorize NASH THERAPEUTIC SERVICES 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 or Provider

_____
Address **City / State** **ZIP** **Phone**

Description of information to be exchanged / released / obtained:
❒ Education records
❒ Evaluation/assessment/eligibility records
❒ Medical 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 _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

The purpose if this release is: _____

_____
Signature of Student/Consumer/Patient or Legally Authorized Representative **Date**
or Enter SSN for Digital Signature

_____
PRINT NAME and Relationship of Legally Authorized Representative to Student/Consumer/Patient