AUTHORIZATION TO RELEASE/EXCHANGE PROTECTED HEALTH INFORMATION

Name of Client: ____ Date of Birth: _______________

Parent/Guardian: ____

Address: ____

Phone: ____

I hereby authorize Pinpoint+ Skills Lab, LLC to:

☐Release confidential information to the following individual/agency

and/or

☐Obtain confidential information from the following individual/agency

Individual/Agency: ____

Title: ____

Address: ____

Phone: ____

Fax: ____

Specific Information Authorized (select one or more):

☐Psychological ☐Educational ☐Medical ☐Other: ______________________

I hereby authorize the exchange, mutual use, and/or disclosure of the information described above between Pinpoint+ Skills Lab, LLC and the individual and/or agency listed above.

This authorization will expire:

☐Upon written request to revoke authorization

☐One year from this date

☐On ____________________________________

(Specify date or condition of expiration)

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment
- I may cancel this authorization at any time by submitting a written request to Pinpoint+ Skills Lab, LLC, except where a disclosure has already been made in reliance on my prior authorization

____ _________________________

Parent/Guardian Signature Date