Dr. Colleen Ryan, PhD
Licensed Clinical Psychologist
Autism Spectrum Disorders Specialist

Childhood Autism Treatment Team
Childhood Autism Therapies
P.O. Box 192, 119 Mill Rd
Palmyra WI 53156

262-370-7744 (Scheduling) 262-370-5527 (Billing) 262-495-3005 (Fax)

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION (RELEASE OF INFORMATION)

Child's Name _____ Date of Birth_____

Street Address_____ City_____ State_____ Zip Code_____

I hereby authorize Childhood Autism Treatment Team / Childhood Autism Therapies to obtain/release to/exchange with, the aforementioned child's Health Care Information with his/her provider listed below

_____(Provider)

I release any/all Health Care related information unless I specify limitations below

☐ Specific information released (list below)

_____

I release the described Health Care information for the period **of 5 years** from the signature date below unless I specify an alternate date range here :_____(start date) to _____(end date)

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at USC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the USC Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____
Signature of parent or legal guardian

_____
Signature of witness

_____
Date

I understand that I may revoke this consent at any time except to the extent that it has already been acted upon prior to my revocation. Revocation will be honored upon written notification.