READY SET

ABA

HIPAA AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information:

- Name: _____
- Date of Birth: _____
- Address: _____

I authorize the use or disclosure of the following protected health information:

- Complete Medical Record
- Specific Records (e.g., Lab Reports, Consultation Notes, etc.): _____
- Other (please specify): _____

Recipient Information:

- Name or Entity: Ready Set ABA, LLC
- Phone Number: 704-222-7654
- Phone Number: 1-844-444-0621

Purpose of Disclosure:

- Continuing Care:_____
- Legal/Insurance:_____
- Personal Use:_____
- Research:_____
- Other (please specify): _____

Expiration of Authorization:

- This authorization will expire on: _____
- OR This authorization will expire upon the occurrence of: _____

Acknowledgments and Signature:

- I understand that I may revoke this authorization at any time, except where information has already been disclosed.
- I acknowledge that I am aware of the potential risks of disclosing this information.
- I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing this authorization.

Signature of Patient or Legal Representative:

- _____
- Date: _____
- If signed by a legal representative, state the relationship: _____