***Authorization to Release Information***

Consumer’s Name: Date of Birth:

Consumer’s Social Security Number:

I hereby authorize ShineThru ABA Therapy, LLP to (check one): obtain from the following

 release to the following

Name: Address:

the following documents/information from the records pertaining to services received Date of Service:

The documents to be released are described or listed as:

The records are required for the specific purpose of:

I understand that my authorization will remain effective from the date of my signature until

 , and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

Signature of Consumer/Consumer’s Designated Representative Date

Witness Date