# AUTHORIZATION TO OBTAIN/DISCLOSE INFORMATION

I, _____, parent of _____, DOB: _____

Parent's Full Legal Name | Child's Full Legal Name | Child's Date of Birth

hereby authorize Dr Michelle Macrorie, LLC (dba Autism From The Start®) to release, obtain, and exchange verbal and written information regarding my child to the following agencies and/or persons as indicated below.

| | | |
|---|---|---|
| Company Name (if applicable): | | Individual's Name: |
| Role/Title: | | Address: |
| Phone: | Fax: | Email: |
| Specific Instructions per Family (e.g. only send written reports, contact family before contacting this provider, etc): | | |

The purpose of this disclosure of information is to ensure continuity of care and services across agencies and caregivers in order to meet the needs of this child and his/her family.

This consent for release of information will automatically expire one year from this date unless otherwise specified. All photocopies of this document shall be as valid as the original. The original signed copy will be securely filed in the child's master file at the offices of Autism From The Start®.

I understand that I may revoke this consent at any time by notifying Autism From The Start® in writing, except to the extent that action has already been taken based on my previous consent.

I have read this form and certify that I understand its contents.

Signature Date

Printed Name Relationship to Child: