Behavioral Consultation Services of Northern Arizona (BCSNA) LLC
906 W. University Avenue
Suite 120
Flagstaff, AZ 86001
(928) 522-3780

____
(Client Name)

____
(Date of Birth)

AUTHORIZATION FOR THE EXCHANGE OF MEDICAL/SCHOOL/PSYCHOLOGICAL RECORD INFORMATION

I hereby give permission to ____ to exchange
(Name of person/facility)
medical, social, and psychological information of _____________________________ with
(Client Name)
Behavioral Consultation Services of Northern Arizona (BCSNA) LLC. Please send to the attention of _____________________________.
(Andrew W. Gardner, PhD, BCBA-D)

Restrictions: ____
____.

This authorizes the exchange of patient information between the BCSNA LLC and the aforementioned provider. The form has been fully explained to me and I certify that I understand its contents.

Signature of person authorized to consent for patient: __________________________________
Relationship to patient: ________________________
Date: __________________________________
Address: ____
City: _____________________________ State: _______________ ZIP: _____________

Name of authorized person, facility, or physician: _____________________________________
Address: ____
City: _____________________________ State: _______________ ZIP: _____________
Phone Number: ______________________________

Witness Signature: ____

THIS CONSENT EXPIRES ONE YEAR FROM: _____________________________________
(Today's Date)