



LB LEARNING LAB, LLC- AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ D.O.B. _____, do hereby authorize
(Recipient of The Learning Lab, LLC services) (Date of birth)

_____ to release and exchange information gained from client
(coach/tutor full name)
sessions and from the clinical record regarding my protected health information to:

(Name of person, health care provider, facility, etc)

(Address) _____

(Phone) _____ (Fax) _____

For the purposes of: *(Please check all that apply)*

Follow up: _____

Coordination of care: _____

Other (specified): _____

Information to be released and exchanged includes the following: (Please check all that apply for VERBAL and WRITTEN release and exchange)

(1) VERBAL RELEASE AND EXCHANGE:

Academic _____ Social _____ Medical _____

(2) WRITTEN RELEASE AND EXCHANGE:

Academic _____ Social _____ Medical _____

Valid from _____ to _____.
(today's date) (typically 1 year from today)

I understand that I have the right to rescind this authorization at any time by sending WRITTEN notice to LB Learning Lab, LLC at lauren@lblearninglab.com. I understand that a withdrawal from this release of information is not valid to the extent that the named coach/tutor has acted in confidence on such an authorization.

Client Signature: _____ Date: _____
(12 years or older)

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____