



RELEASE OF INFORMATION FORM

This document indicates the Focus Person/Substitute Decision Maker/Legal Guardian's choice to add the following: **THERAPEUTIC CONSULTATION SERVICE(S)**
Family and Individual Support (FIS) or Community Living (CL) DD WAIVER ONLY
 Provider below is hereby authorized to exchange health information for:

PROVIDER NAME/ ORGANIZATION			SERVICES
Training Hearts LLC			97139 –
NPI#	1588484588	PRSS ID #	30018029340001

FOCUS PERSON INFORMATION:

First & Last Name			
Birthdate		Medicaid #	

PARENT/ LEGAL GUARDIAN/ SUBSTITUTE DECISION MAKER INFORMATION:

First & Last Name			
Primary Contact #			
Guardianship	Yes	No	
Power of Attorney	Yes	No	

Please list all persons/parties/entities with whom information can be exchanged with:

Service Coordinator(s)/ Case Manager (SC/CM); Providers assigned to ISP;

Focus Person/Decision Maker's signature indicates the choice of Provider(s) of Therapeutic Consultative Service to implement the Individual's Support Plan.

Patient Rights: I understand that I may revoke this authorization at any time by submitting a written request to Training Hearts. I understand that once information is disclosed, it will still be protected under HIPAA privacy laws. I have read and understand this form. I authorize the release of the information specified above.

Focus Person:		Date:	
Decision Maker:		Date:	