Harmony House LLC ABA
Consent for Collaboration Form

Client Information

Client Name: _____
Date of Birth: _____
Parent/Guardian Name (if applicable): _____

Authorization for Collaboration

I, _____ (client/parent/guardian), authorize Harmony House ABA to collaborate and share relevant information with the following external providers for the purpose of coordinated care.

Authorized Parties for Collaboration

☐ School/Educational Staff (Name/School): _____
☐ Physician/Medical Provider: _____
☐ Therapist (Speech/OT/PT/Mental Health): _____
☐ Social Worker/Case Manager: _____
☐ Other: _____

Information to be Shared

☐ Assessment Results
☐ Treatment Plans
☐ Progress Notes
☐ Behavioral Data
☐ Attendance Records
☐ Other: _____

Purpose of Collaboration

☐ Coordination of Care
☐ Educational Planning
☐ Medical/Therapeutic Coordination
☐ Other: _____

Consent Duration

This consent is valid until: _____
(If no date specified, consent will expire one year from signature or end of services.)

Acknowledgment and Consent

I understand that:
- This consent is voluntary and may be revoked at any time in writing.
- Information shared may no longer be protected once disclosed to third parties. - Refusal to consent will not affect my access to services.

Signatures

Client/Guardian Name: _____

Signature: _____

Date: _____

Provider Representative: _____

Signature: _____

Date: _____