



ABA Today



ABA4Autism



ABA New England



Gateway4ABA

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## Coordination of Care Authorization

This fillable form may be used for ABA New England, ABA4Autism, ABA Today, or Gateway4ABA. Complete the applicable company selection and signature sections contained in the form.

### **Before completing this form**

Open the PDF in a compatible viewer to enter information and save your responses.



ABA Today



ABA4Autism



ABA New England



Gateway4ABA

HEREAFTER: "The Companies"

NOTE: This form can be used for one or more of the listed companies. See the signature page for the applicable company(ies).

## Coordination of Care Authorization

| Information                          |                                                                                                                                |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| Client Name                          |                                                                                                                                |
| Date of Birth                        |                                                                                                                                |
| Parent/Guardian Name(s)              |                                                                                                                                |
| Relationship to Client               |                                                                                                                                |
| Effective Date of Authorization      |                                                                                                                                |
| Expiration Date <i>If Applicable</i> | <input type="checkbox"/> One Year From Signature<br><input type="checkbox"/> Upon Discharge<br><input type="checkbox"/> Other: |

### 01. Purpose of This Authorization

The Companies believe that collaboration among service providers is essential to delivering high-quality, ethical, and effective Applied Behavior Analysis (ABA) services.

This form authorizes **The Companies** to communicate and coordinate care with other professionals and organizations involved in the Client's treatment, education, or medical care, as permitted by law.

### 02. Providers / Entities Authorized for Coordination of Care

I authorize **The Companies** (ABA service providers operating under affiliated entities: ABA Today, ABA4Autism, ABA New England, Gateway4ABA) to coordinate care with the following:

|                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Check all that apply and complete as needed | <input type="checkbox"/> Pediatrician / Primary Care Provider<br><input type="checkbox"/> Developmental Pediatrician<br><input type="checkbox"/> Psychologist / Psychiatrist<br><input type="checkbox"/> Speech-Language Pathologist<br><input type="checkbox"/> Occupational Therapist / Physical Therapist<br><input type="checkbox"/> School / School District / IEP Team<br><input type="checkbox"/> Early Intervention Program |
|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                           |                                                                                                                                                                       |
|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                           | <input type="checkbox"/> Case Manager / Care Coordinator<br><input type="checkbox"/> Insurance Company / Managed Care Organization<br><input type="checkbox"/> Other: |
| Specific Provider or Organization Name(s) |                                                                                                                                                                       |

### 03. Types of Information That May Be Shared

The following information may be exchanged solely for treatment coordination purposes:

- ☐ Diagnostic and evaluation information
- ☐ Treatment goals, progress summaries, and clinical recommendations
- ☐ Behavioral intervention strategies
- ☐ Attendance and participation information
- ☐ Medical or education considerations relevant to ABA services
- ☐ Insurance authorization and care coordination details
- ☐ Other (specify):

**Please note:** No psychotherapy notes will be shared unless explicitly authorized by law.

### 04. Methods of Coordination

Coordination of care may occur via:

- Secure email
- Phone consultation
- Written reports
- Treatment team meetings
- School meetings (including IEP or 504 meetings)
- Other secure communication methods as permitted by law

## 05. Limits of Authorization

- Information shared will be limited to what is **necessary for coordination of care**.
- This authorization does **not** permit the release of records for purposes unrelated to treatment coordination.
- Coordination does not replace parental decision-making authority.

## 06. Right to Revoke

I understand that I may revoke this authorization at any time by submitting a written request to The Companies. Revocation will not apply to actions already taken in reliance on this authorization.

## 07. State-Specific Notices

### Virginia

This authorization complies with applicable Virginia confidentiality and health information privacy laws. Coordination of care is limited to treatment, payment, and healthcare operations unless otherwise required or permitted by law.

### New Hampshire

This authorization complies with New Hampshire confidentiality and healthcare privacy requirements. Information will only be shared as permitted by law for care coordination purposes.

### Massachusetts

This authorization complies with Massachusetts confidentiality laws, including protections for behavioral health information. Only the minimum necessary information will be shared for treatment coordination.

### Other States

If services are provided in another state, coordination of care will follow all applicable state and federal confidentiality and privacy laws.

## 08. Acknowledgment & Authorization

I acknowledge that I have read and understand this Coordination of Care Authorization. I voluntarily authorize The Companies to coordinate care as described above.

*See Signature Page Below*



**ABA Today**  
EIN: 83-1284899



**ABA4Autism**  
EIN: 46-2924423



**ABA New England**  
EIN: 88-3984639



**Gateway4ABA**  
EIN: 86-2549483

INSTRUCTIONS:

*Signatory should sign under the banner(s) of the relevant company(ies) from which they are receiving services or employment.*

**ABA Today**

Signatory Printed Name

Manager Printed Name

Signatory Signature

Manager Signature

Date Signed

Date Signed

**ABA4Autism**

Signatory Printed Name

Manager Printed Name

Signatory Signature

Manager Signature

Date Signed

Date Signed

**ABA New England**

Signatory Printed Name

Manager Printed Name

Signatory Signature

Manager Signature

Date Signed

Date Signed

**Gateway4ABA**

Signatory Printed Name

Manager Printed Name

Signatory Signature

Manager Signature

Date Signed

Date Signed