

# AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_, authorize Acadiana Community Based Services, Inc.  
client/guardian  
to disclose information and records concerning the treatment of:

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PARENTS' NAMES: \_\_\_\_\_

This information is to be released to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The disclosure authorized herein will be used for the following purpose:

Such disclosure will be limited to the following specific types of information and communication:

- |  |  |
|--|--|
| <input type="checkbox"/> Telephone and/or letter                         | <input type="checkbox"/> Medication Sheets             |
| <input type="checkbox"/> School Reports/I.E.P.(s)                        | <input type="checkbox"/> Medical Tests/Reports and Dx. |
| <input type="checkbox"/> Psychiatric/Psychological Tests/Reports and Dx. |  |
| <input type="checkbox"/> Other (specify):                                |  |

This consent expires 1 (one) year from date signed below and may be revoked at any time by the client.

\_\_\_\_\_  
DATE PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
WITNESS CLIENT, IF OVER 17 YEARS OF AGE