AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________, authorize ____
client/guardian agency/individual
to disclose information and records concerning the treatment of:

NAME: ____

DATE OF BIRTH: ____

ADDRESS: ____

____

PARENTS' NAMES: ____

This information is to be released to:

ACADIANA COMMUNITY BASED SERVICES, INC.
412 W. UNIVERISTY, SUITE 105
LAFAYETTE, LA 70506
Phone: (337) 261-1571

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:

___ Telephone and/or letter

___ School Reports/I.E.P.(s)

___ Medication Sheets

___ Medical Tests/Reports and Dx.

___ Psychiatric/Psychological Tests/Reports and Dx.

___ 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