

# 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:

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

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)
- Psychiatric/Psychological Tests/Reports and Dx.
- Other (specify):
- Medication Sheets
- Medical Tests/Reports and Dx.

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