AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, for _____,
(PATIENT/PARENT/GUARDIAN) (PATIENT NAME)

(____/____/____) hereby authorize _____
(DATE OF BIRTH) (NAME, ADDRESS & PHONE NO. OF PERSON/AGENCY MAKING DISCLOSURES)

to release the following information from the record:

- ❑ Classroom Observation
- ❑ Medical Record
- ❑ Psychological Evaluation Test Report
- ❑ Referral Summary
- ❑ Social/Family History (completed by patient)
- ❑ Treatment Summary
- ❑ Verbal Communication
- ❑ Other (specify) _____

to _____.
(NAME, ADDRESS & PHONE NO. OF PERSON/AGENCY TO WHOM INFORMATION IS BEING RELEASED)

The dates of treatment covered by this release are _____.

This consent is subject to revocation at any time, and if not expressly revoked, this consent will expire 180 days after the date below.

_____ _____
(SIGNATURE OF PATIENT OR PARENT/GUARDIAN) (DATE)