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Authorization to Release Information

I, _____, authorize_____

to: ___ (send) ___ (receive) the following: ___ (to) ___ (from) the following agencies or people:

_____
Name Address City State Zip Phone

( ) Entire Record
( ) Diagnosis
( ) Case Notes
( ) Treatment Summary
( ) Discharge Summary
( ) Psychological History
( ) Progress Reports
( ) Psychological Testing Results
( ) Academic Testing Results
( ) Summary Reports
( ) Intelligence Testing Results
( ) Medical Reports
( ) Other (specify) _____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program
( ) Evaluation
( ) Case Review
( ) Updating Files
( ) Other (specify)

_____

_____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Signature of Client _____ Date_____

Signature of Parent/Guardian _____ Date_____

Signature of Witness _____Date_____