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AUTHORIZATION OF RELEASE OF INFORMATION

Name of Patient: _____

Birthdate: _____/_____/_____

I authorize _____ (name of therapist) to release information about the educational, social, behavioral, and/or psychological functioning of _____ (name of patient),

to _____, for the purpose of

_____ (i.e., school consultation, testing, treatment planning).

This authorization for release of information will be valid until ____/____/_____.

This information will be treated as confidential and will not be released to a third party without written consent.

I understand that signing this authorization is optional and that I may revoke my consent at any time.

Signature of patient (if twelve years or older): _____

Signature of parent/guardian (if minor): _____

Signature of witness: _____

Date: _____/_____/_____