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AUTHORIZATION FOR RELEASE OF INFORMATION

______________________________ ______________________________
Name of client Name of second client (if couple)

____
Address / city / state / zip code

I / We authorize: ____
Name of individual and/or organization

____
Address

____
Phone and fax number

To release to: ____
Name of individual and/or organization

____
Address

____
Phone and fax number

Information from the records maintained while involved with that facility during the time period of ____________________________________. The information to be disclosed is:

_____ two way
_____ consultation report
_____ school reports
_____ I.Q. testing reports
_____ intake reports
_____ medical reports
_____ psychological testing reports
_____ education proficiency reports
______ progress summary
______ legal reports
_____ other: _________________

This information is requested for the following purposes: ____

I understand that I may revoke this consent at any time by written notice and that upon fulfillment of the above stated purposes or at the end of one year, whichever is first, this consent will automatically expire.

____ ______________________
Signature of client Date

____
Signature of second client (if couple)

____
Signature of parent or legal guardian (if minor)