RELEASE OF INFORMATION

Client Name____ Phone_______________________

Client Address____

City____ Zip Code______________ Age_____

I AUTHORIZE ____

TO OBTAIN FROM/OR FURNISH TO:

Attn:____

Agency Name____

Phone Number____

Address____

____

INFORMATION CONTAINED IN MY MEDICAL RECORDS, FOR THE FOLLOWING PURPOSES:

- ❑ Consultation information and forms.
- ❑ Psychological Testing.
- ❑ Other:____

This authorization is valid for one year from the date below. I understand that this information may not be released to any other organization without my permission. I release the source of these records from any liability arising from their release. A photocopy of this authorization shall be considered valid.

Client Signature_______________________________________ Date_______________________

Parent/Guardian_______________________________________ Date_______________________