AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize the above named clinician to

DISCLOSE to / OBTAIN from _____
_____
_____
_____

the following information about (circle one)

ME

MY CHILD, _____ (date of birth_____):

□ All records and information, no exclusions

□ Other_____

I understand the need for, and the implications of, this authorization for release of information, and this authorization and request to release or obtain information is being made voluntarily on my part. I understand that I may revoke this consent in writing at any time except to the extent that action based on this consent has already been taken. I understand that unless I revoke this release, it remains effective indefinitely.

_____ _____
Date Signature of Client

OR

_____ _____
Date Signature of Parent/Legal Guardian

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