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Authorization for Release of Information

I, ______________________________________ _______________ of____________________
Name Address

____.
City State Zip
DOB______________
Hereby Authorize____ to disclose
to_______________________________ the following specific
information____
____
for the purpose of coordinating Medical and Psychiatric evaluation and treatment.

I have been informed of the type of information being released and that treatment is not contingent upon my decision concerning the signing of the release. I understand that I may revoke this consent at any time. This consent automatically expires in one year unless specifically stated.

Signature____, Date___________________
Client
____, Date___________________
Parent/Legal Guardian
____, Date___________________
Witness