



## 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