AUTHORIZATION TO RELEASE INFORMATION REGARDING MINORS OR DEPENDENTS

I declare that as the legal parent or guardian of

_____ ,
(minor or dependent name)

I do/do not (circle one) authorize the release of information, records, and consultation

from _____ to _____.
(therapist name) (other consulting person or agency)

I further do/do not (circle one) authorize the release of information, records, and consultation

from _____ to _____.
(other consulting person or agency) (therapist name)

Restrictions to this release, if any, are as follows:

_____

The exchange of information may be in the form of written or verbal responses, including the telephone, e-mail, and fax. This authorization will be valid for 1 year from the date signed below.

Guardian Signature _____ Date _____

Printed Name _____

Relationship to Minor or Dependent _____

Therapist _____ Printed Name _____
Phone _____ FAX _____

Consulting person or agency _____
Phone _____ FAX _____