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AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____

Date of Birth: _____

Date: _____

I hereby give:

Name: _____

Address: _____

Phone number: _____

permission to release the following information: (check those that apply)

- ☐ Behavioral
- ☐ Emotional
- ☐ Cognitive
- ☐ Academic functioning
- ☐ Therapeutic goals
- ☐ Therapeutic progress
- ☐ Therapeutic treatment recommendations

To:

Name: _____

Address: _____

Phone number: _____

for the purpose of facilitating consultation, therapeutic treatment, or psychological evaluations.

_____ _____

Client or Legal Guardian Witness