AUTHORIZATION TO RELEASE INFORMATION

Client Name:_____Date of Birth:_____

This form authorizes information from my records (or my child's) to be shared between:

_____

Name of Agency, School or Person Phone

_____

Street Address City Zip

I give permission to Jennifer Fairchild, LCSW and the agency or person above to share the following information:

___ Educational ___ Psychiatric

___ Medical ___ Social

___ Psychological ___ Psychometric (Testing)

___Other (Specify) : _____

I understand that I may revoke this consent at any time and that this authorization is valid for six months from the date listed below. I also understand that this information may not be released to any other person or organization without my permission in writing.

_____

Signature of Parent (if under 18) or Client Date

_____

Printed Name of Parent or Client