PERMISSION TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

Name of Client: ____
Date of Birth: ____/____/____

I hereby give consent to _________________________________ (*name of therapist or practice*) to exchange pertinent and relevant information with the individual/agency identified below.

Name: ____

Agency: ____

Street: ____

City/State/Zip: ____

Phone: __________________________________ Fax: ___________________________

Information obtained may include (*check all that apply*):

- ☐ Clinical impressions and records
- ☐ Academic records (cumulative records, report cards, standardized test scores, etc.)
- ☐ Health records
- ☐ Special education records (504 plan/IEP/PPT/team minutes, evaluations)
- ☐ Psychiatric evaluations
- ☐ Psychological evaluations
- ☐ Social work evaluations
- ☐ Educational evaluations
- ☐ Speech and language evaluations
- ☐ Other evaluations (vocational, occupational, etc.)
- ☐ Other ____

Client or Parent/Guardian Signature: ____

Print Name: ____

Relationship to Client: ____

Date: _____________________

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