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## Authorization for Release of and/or Exchange of Information

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Child's Date of Birth

NAME OF PERSON OR AGENCY PERMISSION IS GRANTED TO SHARE INFORMATION WITH:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code

I, \_\_\_\_\_, hereby give Diane D. Barghi, M.Ed., LPC permission for the mutual exchange of pertinent information regarding my child/family with the above named person/agency, including academic, social, medical, psychological, and/or psychiatric information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code

THIS CONSENT EXPIRES ONE YEAR FROM DATE SIGNED, UNLESS AN EARLIER EXPIRATION DATE IS ENTERED HERE \_\_\_\_\_.