

Authorization for Release of and/or Exchange of Information

Please print:

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 Dr. Michelle M. Forrester 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 _____.