Michelle M. Forrester, Ph.D.
Licensed Psychologist #2-5359

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: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Name: _____

Phone: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Name: _____

Phone: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Check One:

_____ I authorize the release of any records that have been obtained by the office of Dr. Michelle M. Forrester from other providers.

_____ I DO NOT authorize the release of records, in the possession of the office of Dr. Michelle M. Forrester, that have been obtained from other providers.

I, _____, hereby give the office of 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.

_____ _____
Parent/Guardian Signature Date