

CONSENT AND AUTHORIZATION TO RELEASE PSYCHOLOGICAL,
MEDICAL, SOCIAL, LEGAL, AND EDUCATIONAL RECORDS

Pursuant to Federal Guidelines concerning my right to confidentiality, I

(Full Name)

(Date of Birth)

Authorize

(Name and Address of Person or Organization)

To release/exchange psychological, medical, social, legal, and educational records or information concerning me to/with

(Name and Address of Person or Organization)

For the specific purpose of:

I understand that I may revoke this consent to the release of information in writing at any time and that this consent will expire no later than sixty (60) days from the date signed below. I further understand that any release which has been made prior to my written revocation and which was made in reliance upon this authorization shall not constitute a breach of my right of confidentiality.

(Signature)

(Date)

(Signature)

(Date)

If the above named person is a minor child, his/her parent or guardian must also sign.

(Signature)

(Date)