THIS IS ONLY A SAMPLE PLEASE WRITE YOUR OWN BASED ON THE SPECIFIC NEEDS/SITUATIONS OF YOUR PRACTICE

PERMISSION FOR EXCHANGE OF INFORMATION

I,	, hereby authorize		
to RELEASE / RECEIVE informat		Practitioner/Provider	
		тс	O /FROM
PERSON/ORGANIZATION/PROV	/IDER		
ADDRESS			
THE FOLLOWING INFORMATION	N MAY BE RELEASED/REC	EIVED:	
Intake/AssessmentPsychiatric EvalPsychological EvalProgress NotesTreatment PlanDischarge SummaryVocational Skills Assessment	Medical ReportsNeurological ReportsPhysical ExamImmunizations Laboratory Testing	Individual Education Plan Teacher Observations Achievement Tests	
Other:			
For the purpose of:			
Effective Date(s) From:		To:	
for a period not exceeding 1 year. A photocopy of this authorization withat the policy of former Practice recipient of services which, in the policy of Practice of services which, in the policy of	However, I may revoke this will be considered valid, and a street titioner/Provider he judgment of its personnalso the policy ofPractitione		ted communication. lence. I understand n about a present or pose for which the
Member Signature (14 yrs.and old	ler)	Date	
Parent(s)/Legal Guardian(s) and F	, 	 Date	
r aleni(s)/Legal Guardian(s) and r	Celationship to Child	Date	
Witness (Signature and Title)	-	Date	_
To be completed if the recipient or behaviorally, that he/she con		nable to provide a signature, but has	indicated, verbally
We affirm that the nature of this consent, and free from this date to communication to the treating provided in the communication of the treating provided in the communication of the treating provided in the communication of the	(1 years hence).	was physically unable to provide a signeral consent. This authorization shawever, this may be revoked by well as the consensus of the consensu	nall remain effective
Witness (Signature and Relat	ionship)	Date	