CONSENT FOR RELEASE OF INFORMATION

I/We hereby authorize: ATTN: _____
Name: _____
Address: _____
_____

to release any medical, psychological, educational, or social information which may pertain to my/our son/daughter, conservatee/ward, or myself.

_____, TO:
(person=s name)

Name: _____
Address: _____
_____

I understand the information received will be used for evaluation to determine my eligibility to receive services and/or to provide services to me. This authorization for release of information will become invalid one year from signature date.

The question of privacy between myself and the institution, agency, school, the attending physician or physicians is hereby waived. You may furnish copies of all or any desired parts of any record you maintain.

You are hereby released from all legal liability that may arise from the release of information requested. I understand that I may receive a copy of this authorization.

A photocopy is as valid as an original.

Signature: _____
(Consumer, where applicable) (Date)

Signature: _____
(Father) (Date)

Signature: _____
(Mother) (Date)

Signature: _____
(Conservator or Guardian) (Date)

Signature: _____
(Witness) (Date)