all belong
CENTER FOR INCLUSIVE EDUCATION

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION – MINOR

1. I, as parent or guardian of _____
DOB _____/_____/_____, hereby authorize:

Name/Organization: _____
Address: _____
Phone: _____

This information is to be released to the following:

Name/Organization: _____
Address: _____
Phone: _____

2. Specific information to be released:

- ❒ Summary of Treatment
- ❒ Psychosocial History
- ❒ Psychological Report
- ❒ Medication/Medical Review
- ❒ Verbal Consultation
- ❒ Academic Records
- ❒ Teacher Report
- ❒ Other: _____

3. Purpose of disclosure:

- ❒ Evaluation & Assessment
- ❒ Continuity of Care
- ❒ Treatment Planning
- ❒ Family Involvement
- ❒ Referral to Another Professional
- ❒ Contact with Referral Source
- ❒ Other: _____

4. I understand that this consent can be revoked in writing at any time. Revoking this consent will not affect information already released. Without the expressed revocation, this consent expires 12 months from today or on the date identified below.

Expiration Date: _____/_____/_____

5. My signature verifies that I understand what information is to be released and the intended purpose of the information.

_____ _____/_____/_____ _____
(Client Signature) (Date) (Witness Signature)

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