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RELEASE OF INFORMATION

PERSONAL

I, _____, authorize _____

to disclose, release and/or obtain records to/from:

My primary care physician, Dr. _____

My family member(s) _____

My lawyer _____

Other _____

Information relating to my admission, diagnosis, social history, school data,
psychological tests, treatment progress and/or _____

For purpose of evaluation and treatment covering the period of time from _____

_____ to _____

I understand this authorization expires on _____ and can be
revoked by me at any time.

Signature

Date

Parent, Guardian or Legal Representative

