

Authorization for Release of and/or Exchange of Information

Please print:

Child's Name

Child's Date of Birth

Name of Person or Agency Permission is Granted to Share Information with:

Name: _____

Phone: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Name: _____

Phone: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Name: _____

Phone: _____

Consent expires one year from date signed unless earlier expiration date is entered here: _____

Check One:

____ **I authorize the release of any records that have been obtained by the office of Dr. Michelle M. Forrester from other providers.**

____ **I DO NOT authorize the release of records, in the possession of the office of Dr. Michelle M. Forrester, that have been obtained from other providers.**

I, _____, hereby give the office of Dr. Michelle M. Forrester permission for the mutual exchange of pertinent information regarding my child/family with the above named person/agency, including academic, social, medical, psychological, and/or psychiatric information.

Parent/Guardian Signature

Date