



AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____ DOB: _____

I, _____ (client or legal guardian), hereby authorize Coastal Therapy and Learning Center to send and/or receive information (as noted below) to and/or from:

Name of Person or Facility: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

- Academic testing results, Psychological testing results, Behavior programs, Service plans, Progress reports, Summary reports, Intelligence testing results, Medical reports, School records, Entire record, Personality profiles, Other (specify): _____, Psychological reports

The above information will be used for the following purposes:

- Planning appropriate treatment or program, Continuing appropriate treatment or program, Determining eligibility for benefits or program, Case review, Updating files, Other (specify): _____

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Patient Signature (if over 18 years or emancipated): _____ Date _____

For minors:

Legal Guardian Signature _____ Date _____

Legal Guardian Signature _____ Date _____