



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: _____

- | | |
|---|--|
| <input type="checkbox"/> Academic testing results | <input type="checkbox"/> Psychological testing results |
| <input type="checkbox"/> Behavior programs | <input type="checkbox"/> Service plans |
| <input type="checkbox"/> Progress reports | <input type="checkbox"/> Summary reports |
| <input type="checkbox"/> Intelligence testing results | <input type="checkbox"/> Medical reports |
| <input type="checkbox"/> School records | <input type="checkbox"/> Entire record |
| <input type="checkbox"/> Personality profiles | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> 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 _____