Consent to Release Information

Client Name_____Date of Birth_____

This consent to release information form authorizes information from my medical, psychological, psychiatric and educational records (or my child's records) to be shared between CCH Racquel A. Knight and the professional/group/agency school below:

_____ Educational _____ Psychiatric _____ Medical _____ Social

_____ Psychological _____ Psychometric

-

I understand that this authorization is valid for one year from the date below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

_____ _____

Health Professional, Group, or School Person/Individual

_____ _____

Street Address Date

_____ _____

City/State and Zip Code Phone Number/s

_____ _____

Signature of Client/Parent/Guardian Printed Name of Client/Parent/Guardian