Consent to Release and Exchange Information

Client name: ____

DOB: _______________ SS#: ____________________________________

Name of school, medical agency, DCFS, therapist, other: ______________________________________

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Address: ____

City: _____________________ State: _______________ Zip: ________________

Phone/Fax: _______________________ Contact Person: ______________________________________

By my signature below, I give my consent to release/exchange information regarding myself/my child, to his/her service provider as it pertains to the following for the purpose of service coordination and continuity of care (check all that apply):

_____ Behavioral concerns _____Test/assessment results _____ Progress reports ____ Attendance reports _____ Social skills

_____ IEP summary ____ Treatment plan _____ other:

____

I further authorize the service provider to share information with personnel as deemed necessary in order to help them assist, understand, accommodate or monitor myself/ child within the environment. If there is information I prefer the provider to not share, I recognize that it is my responsibility to make that known to him/her. This consent shall remain in effect until I revoke it in writing.

By your signature below, you acknowledge that you have read, and agree to, the foregoing.

Client Name (please print) ____

Client/Guardian Signature ____ Date ______________

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