



AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____ DOB: _____

I, _____ (client or legal guardian), hereby authorize KidSpeak to SEND and/or RECEIVE information (as noted below) TO and/or FROM:

Name of Person or Facility: _____ Phone: _____

Address: _____

- 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 of 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 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 purposes and who will receive the information. I understand that I have a right to receive a signed copy of this authorization. I understand that I have the right to refuse to sign this authorization.

Signed by: _____ Signature of Patient or Legal Guardian Relationship to Patient

_____ Print Patient's Name Date

_____ Print Name of Patient or Legal Guardian, if applicable