AUTHORIZATION FOR RELEASE OF INFORMATION

Name(s):_____;_____;_____;_____

Date of Birth: _____; _____;_____;_____

Child's (Children's) Address: _____

I hereby authorize Red Oaks Coping Staff to:
□ OBTAIN INFORMATION FROM, and/or
□ PROVIDE INFORMATION TO

___ Name: _____Phone: _____

Address: _____

___ Name:_____Phone: _____

Address:_____

___ Name:_____Phone: _____

Address: _____

___ If initialed, this release is only for the purpose of communicating that your family is receiving ROC's support.

Release of information, both written and verbal, is requested explicitly for the purposes of the enhancement of the client's psychosocial intervention and continuity of care.
RESTRICTIONS: _____

_____

This release of information is valid from the date of initial contact between the client and the above named parties through one year from the date indicated below. This release of information may be revoked at any time by the persons signed below. All revocations must be in writing and signed.

_____
Client Signature Date

_____
Parent/Guardian Signature Date

_____
Witnessed by Date