THE CENTER FOR LIFESPAN DEVELOPMENT

AUTHORIZATION TO RELEASE INFORMATION

Name of Client

Date of Birth

Social Security #

I understand that the purpose of this release is to assist with my child's treatment by improving communication between professional service providers at The Center for LifeSpan Development, Inc. and important individual(s) in my child's life. To further this goal, I authorize

to release information regarding my child to assist in his/her therapy.

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire within one year of the date of this document or upon conclusion of my child's services, whichever comes first.

Signature of Client / Parent Guardian

Date

Printed Name

Relationship to Child

Signature of Client (Child)

Date

THE CENTER FOR LIFESPAN DEVELOPMENT
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