## Authorization for Release of Confidential Information

Client Name: _____ Date of Birth: _____

Name of Agency, School or Practitioner: _____

Address and Telephone #:_____

I do ___ do not ___ authorize the above named agency, school or practitioner to provide the following

information regarding _____ to Kids In Sync:

{} Confirmation of application for services
{} Mental Health report of intake, assessment, diagnosis and/or service recommendations
{} Mental Health report of treatment and/or interventions
{} Mental Health closing or discharge summary/report
{} Psychological and/or psycho-educational report and discussion of findings
{} Referral information
{} Observations and/or reports of _____'s academic, social, emotional and behavioral functioning
{} Substance abuse assessments, evaluations, reports and treatment summaries
{} Other (specify) _____

For the purpose of _____

I do ___ do not ___ authorize Kids in Sync to provide the following information regarding _____ to the above named agency, school or practitioner
{} Report of intake, assessment, diagnosis and service recommendations
{} Occupational Therapy treatment and/ or interventions
{} Discussion of _____'s functional independence, social, emotional and behavioral functioning
{} Other (specify) _____

For the following period of time _____
(If treatment period is unspecified, only records from the past 6 months will be released)

This consent is valid until _____

**Understand that I may revoke this consent at any time by giving a written notice to Kids in Sync, and that I have the right to inspect and copy the information disclosed by him. It has been explained to me that if I refuse to consent to release of information services may be delayed or denied.**

Signature of Client _____Date _____

Signature of Responsible Party _____ Date _____
(Must sign if client is under 18 years of age)

Relationship of responsible party to client _____

Signature of Witness _____ Date_____