Release of Information

First Parent/Guardian			
First Name		Last Name	
Phone Number			
Email		Relationship	
May we contact this person to coordinate your services?		☐ Yes ☐ No ☐ Yes with limitations:	

Client's School			
Name of School		School District	
Counselor/Advisor		Phone #	
Email		Fax #	
Address			
State, ZIP			
May we contact this person to coordinate your services?		☐ Yes ☐ No ☐ Yes with limitations:	

Other Helpful Contacts (Second Parent, Coach, Etc.)			
First Name		Last Name	
Relationship		Phone #	
Email		Fax #	
Address			
City, State, ZIP			
May we contact this person to coordinate your services?		☐ Yes ☐ No ☐ Yes with limitations:	

Acknowledgement

1. I authorize the mutual disclosure of the information to be released to the Playground and the above listed professionals.
2. I understand that the purpose of this disclosure of information is to improve assessment and treatment services. treatment planning, share information relevant to treatment, and coordinate
3. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to The Playground.
4. I understand that a revocation of this authorization is not effective to the extent that action has been taken in reliance on the authorization.
5. I understand that my treatment is not conditioned to whether I sign this authorization.

I wish for this release to remain in place as long as my file is open.

OR, I wish for this release to expire in (circle on) 30, 60,90,120

Date of Birth	
Printed Name	
Client Signature *if 13 or over* or	
Legal Gaurdian if under 13	
Date	