Release/Obtain Medical, Psychiatric and Legal Records

Name of Student: _____DOB_____

I hereby authorize Logos to release and/or obtain information from:

Name/Organization _____

Address _____City/State/Zip Code_____

Phone:_____Fax:_____

I also hereby authorize the above name/organization and its agents/employees to disclose medical/psychiatric/legal records and/or verbal information related to the student's course of diagnosis and treatment to:

Logos
9137 Old Bonhomme
St. Louis, MO 63132
Phone: (314) 997-7002
Fax: (314) 997-6848

- The disclosure of records/information authorized herein is required for the purpose to facilitate educational and therapeutic services.
- *This consent may be revoked at any time in writing. This consent shall expire one year from the date of the signature or upon withdrawal from Logos.*
- This information may not be used to initiate or substantiate any criminal charges against above named client or to conduct an investigation of client

My signature below shows that I understand and agree with all of these statements.

_____ _____

Parent/Guardian Signature Date