



**Authorization for Release of Records and Information**

\_\_\_\_\_, give my permission to \_\_\_\_\_  
(Name parent/guardian or emancipated student) (Name of facility)

to (release, obtain) copies of the following records and/or information: \_\_\_\_\_

about my (self, child): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Student's full name)

(to, from): \_\_\_\_\_  
(Name of organization or person receiving or providing records)

I understand that these records will be used only for the purpose of: \_\_\_\_\_

(Purpose for which records and/or information will be used)

The authorization is in effect from \_\_\_\_\_ until \_\_\_\_\_.

I understand that, with a few limited exceptions, \_\_\_\_\_  
(Name of facility)

may not obtain or release records and/or information about my (self, child) unless I agree to the request. I understand that I may look at the record and/or information to be released, and I understand the nature of the material to be released. I understand that I give my permission for records and/or information to be obtained from or released to only the person or organization, and for the purpose listed above, and only for the time shown above. I may withdraw my consent at any time in writing or, if I am physically unable to write, by orally advising \_\_\_\_\_.  
(Name of facility)

\_\_\_\_\_  
Staff signature

\_\_\_\_\_  
Signature of parent/guardian of minor child or emancipated student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**If client is unable to sign:**

We affirm that \_\_\_\_\_ was physically unable to sign this authorization, but that he/she gives his/her verbal consent to obtain or release the foregoing records and/or information and understands the nature of this authorization.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date