WILKES-BARRE AREA SCHOOL DISTRICT
AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient/Client:_____ Date:_____

Patient/Client Date of Birth:_____

To:_____

_____
Address

I hereby authorize

_____ To furnish

_____ To receive

A copy of the records of and/or a summary of professional services provided to the above-named patient/client pertaining to:

Clinical evaluation/treatment_____

List information or Records requested_____

_____

Covering the period from_____to_____

You and your agents or employees, are hereby released from all legal responsibility of liability for release of the records to the extent indicated and authorized herein.

WITNESS:

_____ _____
For Patient Signature of Patient

_____ _____
For Authorized Person Signature of Person Authorized to Consent for Patient

Relationship:_____
Parent, Guardian, etc.

Address:_____

_____