

Relationship-based child & adolescent therapy groups

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AUTHORIZATION FOR EXCHANGE AND RELEASE OF INFORMATION

| I authorize | |
|--|---------|
| and | |
| Name: | |
| Address: | |
| | |
| To exchange the following specific information: | |
| | |
| In regard to:myselfmy child | |
| Name: | DOB |
| For the purpose: | |
| | |
| Expiration date:(maximum of one year from date | signed) |
| This authorization is signed with the understanding that the information permission, or be used for any other purpose than that specified above in writing anytime prior to the expiration date. | |
| Signature | Date |