Client Name:_____

Brent Woodall Foundation for Exceptional Children

Authorization for Release of Therapeutic Information

Client's Name:_____

DOB:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

I hereby authorize the Brent Woodall Foundation for Exceptional Children to release and discuss my child's confidential information to the following people, companies, organization:

- ☐ I do not give my permission to release information to anyone.
- ☐ Insurance Company
- ☐ Grant Organizations or 3rd Party Funding Sources
- ☐ Child's School (name of school)_____
- ☐ Other Therapy Providers: (please list name, company, and phone number)

  _____

  _____
- ☐ Family or Friends other than the Child's legal guardians: (please list name, phone number, and relationship to the child)

  _____

  _____

  _____

  This authorization will remain in effect from the date of my signature until revoked upon written notification.

RIGHT TO REVOKE:
I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

_____ _____

Signature of Legal Guardian Date

_____

Relationship to Child