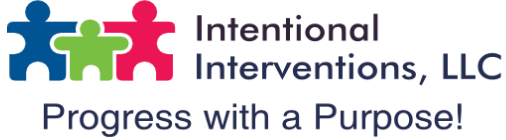

Authorization for Release of Information and Records

I/We hereby give permission and consent to
____
____
____

to release and/or discuss confidential information contained in my child's medical record to the following practitioners located at:

Intentional Interventions. LLC
1501 S New Road
Pleasantville, NJ 08232
Phone: 609-380-1122
Fax: 609-374-9166
info@intentionalinterventions.com

Client's Name:___________________________________ Date of Birth: / /

Parent/Guardian #1: ___________________________________
(Print Name)

Parent/Guardian #1: ___________________________________ Date: _____ / _____ / _____
(Signature)

Parent/Guardian #2: ___________________________________
(Print Name)

Parent/Guardian #2: ___________________________________ Date: _____ / _____ / _____
(Signature)