Authorization for Release of Information and Records

I/We hereby **give permission and consent** to _____________________________________ to release confidential information in my child's clinical record to the following practitioner:

Intentional Interventions, LLC
707 Whitehorse Pike, Absecon, NJ 08201
Phone : 609-380-1122
Fax : 609-374-9166
Email : 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)