Intentional Interventions, LLC
Progress with a Purpose!

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
6712 Washington Ave Suite 205 Egg Harbor, Twp., NJ 08234
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)