Authorization to Release Information

Child's Name: DOB: Gender:

Parent/Guardian: Phone:

Address: City: State: Zip Code:

1. What is the individual's diagnosis?
   a. Autism Spectrum Disorder_____

      Is the individual non-verbal? Yes or No

      Is there a communication device? Yes or No

   b. Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)_____

   c. Other ____ Please Explain_____

2. Race:

   Black_____
   Hispanic_____
   White_____
   Other_____

3. Is there any other ***identifiable information*** that you feel may be helpful (i.e., medical bracelet or tracking device)? _____

Organization(s) to receive information: Autism Rising/Chatham County Police Department/911 Dispatch

I understand that I may revoke this authorization at any time by notifying Autism Rising, in writing. I have read and understand the above statements and do hereby voluntarily consent to the disclosure of the information to those named above. I hereby release Autism Rising from any liability arising from the surrender of this information.

Client/Parent/Guardian signature: Date:

Return form by mail or email:
13051 Abercorn Street, Suite B3 #264
Savannah, GA 31419
Email: info@autismrisinginc.org
912-712-6533

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