Consent to Release Information

Client Name: _____Date of Birth _____

This consent to release information authorizes information from my records (or my child's records) to be shared between Jennifer Rae Struchen_
Art facilitator

And the agency/school listed below.

I give permission to Expressive Soul Art and the agency/school listed below to share the following information:

_____Educational _____Psychiatric

_____ Medical _____Social

_____ Psychological _____Psychometric

I understand that this authorization is valid for six months from the date below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

_____ _____
Agency or School Name Individual

_____ _____
Street Address Date

_____ _____
City/State Zip Witness (counselor)

_____ _____
Signature of Client/Parent/Guardian Printed Name of Client/Parent/Guardian