Family & Child Development

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RELEASE OF INFORMATION

I hereby authorize:

_____

to release ( ) all, or the following designated part(s):

_____

_____

of my medical and/or psychotherapy records, under the name of:

_____

_____

These records may be released to:

_____

_____

_____

SIGNED:

_____

Signature of patient, or, in the case of a minor child, the person authorized to sign. DATE

_____

Printed name of patient, or person authorized to sign for a minor child. DATE

WITNESS:

_____

DATE

_____

Printed name of witness