

RELEASE OF INFORMATION

Re:

Client Name

Birthdate

Address

City. State. ZIP

Parent Name(s) if minor

Phone Number

I hereby authorize:

Clarita Thoms-May, MFC 33419, ILPCC 924

To exchange with the following parties, any reports, medical, educational, behavioral, or social information, that would assist in the development of an educational/treatment plan for the individual named above:

Contact

Phone Number

Signature of client/parent

Date

Relationship to client