RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize release of information concerning _____, whose date of birth is_____. I understand that information will be communicated verbally and or in written form. Information concerning psychiatric, psychological, medical diagnosis, drug or alcohol abuse, economic status, and educational information will be released and/or communicated if indicated below. I authorize the following information to be released to Transitions for Life.

____ Treatment Plans
____ Substance Abuse Treatment Records
____ Treatment / Discharge Summaries
____ Social and/or Developmental History
____ Health / Medical Records
____ Restorative Support Services Academic / School-related Record
____ Social Support Services (Food, Clothing, Shelter)
____ Grades and Test Scores
____ Attendance receive this information, specific individuals must be named
____ Suspensions / Expulsions above
____ Exceptional Student Education / Section 504 records
____Other_____

I acknowledge that all information I authorize to be released or requested will be held strictly confidential. I understand this authorization will expire one (1) year after the date signed.

_____
Print Name

_____
Client Signature and Date