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Authorization for Release of Information from Collateral Source

I, _____, authorize
(Full name of client/ guardian)

(Full name of Person or Organization)

to release or exchange information about me my child _____
(Full name of child)

to the following individual: Mary A. Connell, Ed.D.
(Full name or title of the person to which disclosure is to be made)

100 East Fifteenth Street, Suite 635 Fort Worth TX 76102
(Mailing address and/or phone number if applicable)

I understand that authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment (except for research-related treatment and certain Court-ordered or employment related evaluations). I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

My signature, below, means that I have read this release form and I understand it fully, and voluntarily sign.

Signature of Client

Date

Signature of Parent/Guardian

Date