

Lydia Byhardt Bollinger, LCSW - Remember the Joy Consultation
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CONSENT FOR RELEASE OF INFORMATION

This form may not be altered once signed. It is intended to oversee only the release of information between the parties described below.

Client Name: _____ Birthdate: _____

I authorize (program name): Lydia Byhardt Bollinger, LCSW to

Release information to

Receive information from

_____ address

specific person or agency

_____ phone number

City

State

Zip

I authorize the release of the following information (**initial each type authorized for release**):

___ child's progress at child care center/school

___ family circumstances

___ other (please specify): _____

The purpose or need for the disclosure of information is (**initial each as relevant**):

___ coordination of services

___ other (please specify): _____

I understand that I have the right to cancel this consent for release of information at any time except when the program has already taken action on it. If I wish to cancel this consent, I need to do so in writing. Otherwise, this consent will end one year from the date of the legal guardian's signature.

_____ date

Participant Name (optional)

_____ date

Parent/guardian signature (required if participant is under 18)

_____ date

Witness