



**PERMISSION TO OBTAIN/RELEASE INFORMATION**

Name of Child/Client \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

I hereby give consent to The Southfield Center for Development to obtain/release all pertinent information concerning my child \_\_\_\_\_ or myself \_\_\_\_\_ (check one) from:

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Street: \_\_\_\_\_

City / State/ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Information that may be obtained can include (check all that apply):

- Clinical Impressions and Records
- Academic Records (cumulative records, report cards, standardized test scores, etc.)
- Health Records
- Special Education Records/504 Plan Records (IEP, 504 Plans, PPT/Student Study Team minutes, evaluations)
- Psychiatric Evaluations
- Psychological Evaluations
- Social Work Evaluations
- Educational Evaluations
- Speech and language Evaluations
- Other Evaluations (vocation, occupational, etc.)
- Other \_\_\_\_\_

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Self/Parent/Guardian \_\_\_\_\_ (Print Name)

\_\_\_\_\_ (Relationship)

\_\_\_\_\_ (Signature)

\_\_\_\_\_ (Date)