Permission to Obtain/Release Confidential Information

Name of Client: ____Date of Birth:___/___/___

I hereby give consent to Dr. Cheryl Fultz to exchange pertinent and relevant information with the individual/agency identified below.

Name: ____

Agency:____

Street:____

City/State/Zip_______________________________________

Phone: ____

Fax: ____

Information obtained may 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 (vocational, occupational, etc.)
- ☐ Other ___________________________________

Client/Parent/Guardian Signature: ____

Print Name:____

Relationship to Client: ____

Date: __________________