

Parent(s), this form allows information about your child to be exchanged. Please sign and return it to Partners In Excellence.

Client Release Form

Client's Full Name _____

Date of Birth _____

Parent Name _____

Address _____

I authorize Partners In Excellence to:

_____ release information to: _____ (check either or both, as needed)
 _____ to obtain information from: _____

Name, Title

Organization Phone # Fax #

Address

City State Zip Code

_____ Official school records	_____ Speech Report
_____ Health record	_____ Vision Report
_____ Psychological Report	_____ Hearing Report
_____ Medical Reports (including related services)	_____ Occupational Reports (OT)
_____ Physical Therapy Report	_____ Other _____

The purpose for the request _____

I understand that this authorization takes effect the day that I sign it. It expires on _____ or No more than one year from the date of my signature.

I also understand that I may change this authorization at any time.

Parent Signature

Date