



AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION (80.B)

NAME: _____ DOB: _____ SSN: _____

I, _____, hereby give my consent for Decide to Believe, LLC to

release and/or obtain information to and/or from:

NAME _____	AGENCY _____
ADDRESS _____	CITY/STATE _____
PHONE _____	FAX _____

This information is being released / obtained for the purpose of _____

INFORMATION REQUESTED:

- | | |
|--|--|
| <input type="checkbox"/> Assessments | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Individualized Education Plan | <input type="checkbox"/> Medical History and Physical |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Grades |
| <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Attendance / Disciplinary Records |
| <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> Monthly Update |
| <input type="checkbox"/> Written / Verbal Correspondence | <input type="checkbox"/> Admission Note |
| <input type="checkbox"/> Educational Evaluation | <input type="checkbox"/> Other: _____ |

I was informed of the information requested / released and the benefits of its release

Parent / Legal Guardian Signature

Date

Witness / Decide to Believe, LLC Staff Signature

Date

ANY INDIVIDUAL OR AGENCY RECEIVING THIS CONFIDENTIAL INFORMATION SHALL NOT DISCLOSE THIS INFORMATION TO ANY THIRD PARTY UNLESS THE INDIVIDUAL CONSENTS OR UNLESS THE LAW ALLOWS OR REQUIRES FURTHER DISCLOSURE WITHOUT CONSENT.

ALL BLANK AREAS ON THIS FORM MUST BE COMPLETED PRIOR TO INDIVIDUAL, PARENT/AR SIGNATURE. PHOTO COPY OF THIS COMPLETED RELEASE IS CONSIDERED AS VALID AS ORIGINAL. DURATION OR CONSENT SHALL BE NO LONGER THAN 90 DAYS AFTER TERMINATION OR ONE YEAR, WHICHEVER IS SOONER. THE INDIVIDUAL, PARENT OR AR MAY TERMINATE THIS AUTHORIZATION TO RELEASE INFORMATION AT ANY TIME.

Notice of Revocation _____ Revocation Effective _____
Date Date

Expiration Date