Consent to Release Information

Client Name: _____Date of Birth _____

This consent to release information authorizes information from my medical, psychological, psychiatric and educational records (or my child's records) to be shared between Dr. Bruce Eimer and the health care professional / group / agency / school listed below.

I give permission to Dr. Bruce Eimer and the health care professional / group / agency / school listed below to share the following information:

_____Educational _____Psychiatric

_____ Medical _____Social

_____ Psychological _____Psychometric

I understand that this authorization is valid for six months from the date below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

_____ _____
Health Professional, Group, or School Person / Individual

_____ _____
Street Address Date

_____ _____
City/State Zip Phone Number/s

_____ _____
Signature of Client/Parent/Guardian Printed Name of Client/Parent/Guardian