The Capable Child Release of Information

AUTHORIZATION FOR RELEASE OF RECORDS/INFORMATION

I hereby authorize the mutual exchange of confidential information and the release of records among and between The Capable Child and the person(s) or agency listed below:

To/From:	To/From:
Address:	Address:
City, State:	City, State:
Phone/ Fax:	Phone/ Fax:

Please select which records are permitted to be released:

	Academic Records
	School Records
	Evaluation Records
	Transcripts
	Counseling/ Psychological Records
	Other, please specify

The reason for disclosing the records is:

I understand that the information obtained by The Capable Child will be treated in a confidential manner I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/guardian signature

Date

Address

City, State, Zip