



Authorization for Release/Exchange of Information

I _____ authorize my Therapist _____ to release/exchange information to the following Positive Kids Counsellor:

Counsellor's Name: _____ Ph: _____ Email: _____

Parent Name(s) _____ Phone: _____ Email: _____

Child's Name(s): _____ Child's DOB: _____

Information to be released: (Please Check

- Screening Information
- Behavioral and Psychological Reports
- Treatment Plan
- Counseling Notes
- Coordination of Care
- Intake and History
- Other:

This release/exchange of information is valid as of (Effective Date) _____ and will remain valid until the termination of treatment or authorization from client to revoke. This authorization may be revoked at any time.

Signature of Parent, Guardian or Authorized person:

Date: _____