

Piece of Our Puzzle



IMPROVING THE QUALITY OF LIFE.
KNOWLEDGE AND UNDERSTANDING OF OUR SPECIAL NEEDS CHILDREN.

Piece of Our Puzzle LLC

1 Sugarmaple Lane
Levittown, PA 19055
(484) 569-0377

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

I, _____, hereby authorize Piece of Our Puzzle LLC and the person/organization listed below to release and exchange psychological, educational, medical, and other information about:

Client's Name: _____

DOB: _____

Reason for Release: Continuity of Care

Person/Organization receiving/communicating information:

Name: _____

Address: _____

City, State and Zip: _____

Phone and Fax: _____

I understand that this authorization is valid for the period of time in which my child is an active client with Piece of Our Puzzle LLC. I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

Signature

Date

Signature of Piece of Our Puzzle Staff

Date

Relationship to client: Self Parent Guardian

Date of Form: _____

Expiration Date (one year from above date): _____