

Piece of Our Puzzle LLC 3150 Tremont Ave

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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):**