Piece of Our Puzzle

Piece of Our Puzzle LLC
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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: _________________________

Person/organization receiving/communicating information:

Name: ____

Address: ____

City: ________________________________ State: _______ Zip: _______

Phone: __________________________

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