Lifting Spirits Therapy Services, Inc.

Release of Information

Date: ______________________

Child's Name: ______________________________________

Date of Birth: ______________________________________

Records Requested From: ____

Name: ____

Address: ____

Telephone Number: _______________________________

Requested Records/Information:

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I hereby authorize the release of the records listed above, in reference to my child,

____, to Lifting Spirits Therapy Services, Inc. I understand that confidentially will be maintained as to further distribution of the material will be completed without further written consent.

Signature of Parent/Guardian: __________________________ **Date:** ________________________

P.O. Box 1071 Gainesville, GA 30503 (678) 908 - 7057