Authorization to Release/Obtain Confidential Information

Client: ____DOB:____________________

Parent(s):____

I understand that during the course of our involvement with E. Gordon Associates, it will be necessary for staff to consult with various persons such as doctors, educators, and other outside experts concerning my child. I expressly authorize and consent to E. Gordon Associates' consultation with such professionals and experts on my child's behalf. I understand that in the course of such consultation, E. Gordon Associates may receive or give information that is of a confidential nature.

I hereby authorize E. Gordon Associates to receive and give such information concerning my child in order to provide continuance of care and consulting services. I also authorize my child's physicians, educators, and others who may possess confidential information concerning my child to divulge and deliver that information to E. Gordon Associates. A facsimile of this authorization should be sufficient to authorize the delivery of such information. This authorization shall remain in effect until _______________ or until such time that I/we wish to retain the confidential nature of any such information by advising EGA in writing.

☐ School Staff__________________________

Phone __________________________________

Fax_____________________________________

☐ Dr./Therapist __________________________

Phone __________________________________

Fax ____________________________________

☐ Other Program_________________________

Phone__________________________________

Fax____________________________________

____
Parent/Guardian Signature Date

____
Client Signature (if over 18) Date

Items requested/provided for disclosure:

_______________________ _______________________

_______________________ _______________________

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_______________________ _______________________