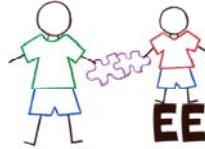


Exceptional Expectations, LLC



Helping families put together the pieces

Parent Authorization for Release/Request of Client Confidential Information

I hereby authorize the release of client information **FROM**:

Name of Agency	Person/Therapist Responsible	City/State	Phone Number
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Name of Agency	Person/Therapist Responsible	City/State	Phone Number
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Name of Agency	Person/Therapist Responsible	City/State	Phone Number
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- Information to be shared:
- Evaluations/Assessments/Diagnostics
 - Therapist notes/reports
 - Child's Work Samples
 - Videos/transcripts of Child's services
 - Other summative information regarding Child's services

I hereby grant permission for confidential information to be released **TO** the following party/parties for purposes limited to those related to the evaluation and treatment of my child.

Name of Individual	Agency	Position	Phone Number
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Name of Individual	Agency	Position	Phone Number
--------------------	--------	----------	--------------

Name of Individual	Agency	Position	Phone Number
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- Information to be shared:
- Evaluations/Assessments/Diagnostics
 - Therapist notes/reports
 - Child's Work Samples
 - Videos/transcripts of Child's services
 - Other summative information regarding Child's services

I understand that I have the right to inspect the contents of any physical records prior to the records being forwarded. The confidential information contained within these records will be shared only with the third party/parties to whom I grant permission. This information shall be used for educational/informational purposes only and will not be conveyed for any other purpose(s).

Potential uses of information include program planning and goal development, training or certification purposes, outside individual/agency consultation, and evaluation, including observation and assessment.

Name of Child	Date of Birth
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Parent or Guardian Signature	Date
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Address	Telephone
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