Authorization for Release of Records or Information

I ____ authorize Dei's Care Consulting Services to consult with and/or collaborate with the following provider, agency or persons for the purpose of

☐ Collaborating ☐ Consulting ☐ Providing ☐ Receiving

Information that is pertinent to both Dei's Care Consulting services and treatment plan of my child,

Client Name: ______________________________________

DOB:______________________________

I understand that I may revoke this authorization for release of records at any time and will provide written consent to do so and Dei's Care will continue collaboration until written consent is provided.

Agency/Provider/Person: ____

Address:____

Phone Number: _______________________________

Email: ____

Parent or Guardian

(Please Print) ____

Signature:____

Date_________________________

Witness (Please Print)

____

Witness Signature: ____

Date__________________________

We may update this form at any time, please check the date given for the latest update. Last updated 5/1/20