## PARENTING 🙀 ON CALL

## AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Dr. Tashya Wilson/Parenting On Call by other individuals or agencies. Such requests should be referred to the original individual or agency.

I,		, parent of,	authorize
	On Call to:	/ I /	
_	release to:		
_	obtain from:		
	exchange with:		
			-
			-
	ving information pertaining to	my child:	
	treatment summary		
	history/intake		
	diagnosis		
	psychological test results		
	psychiatric evaluation/me		
	dates of treatment attenda	ince	
	other (specify)		
for the pu	1		
	evaluation/assessment and	d/or coordinating treatment	efforts
	other (specify)		
	ent will automatically expire of on the following earlier date, ).		
	and I have the right to refuse to	-	

time (except to the extent that the information has already been released).

		Child Date of Birth:	
Signature of Parent/Guardian	Date		

Signature of Witness

Date