



AUTHORIZATION FOR RELEASE OF INFORMATION

Youth Name _____ DOB _____ Med Rec# _____

I request and authorize:

_____ (Person requesting information)

Multi-Agency Alliance for Children, Inc
100 Edgewood Ave., Suite 810
Atlanta, GA 30303
Tel: 404)880-9232 Fax: (404)880-9325

To obtain from:

Person releasing information _____

Name of Institution _____

Address _____

Phone and Fax: _____

Please Send All Applicable Records:

- Immunization Record
- Transcript of Grades
- Withdrawal Grades
- Testing
- Psych Eval & Testing
- Eligibility Report
- Vision & Hearing Screening
- Consent for Placement
- Placement Minutes
- Total Service Plan Including Objectives
- Due Process Check List & Transition Plan
- Consent to Evaluation

Other: _____

This document serves as an open communication release for both parties to exchange information regarding youth progress and placement. I understand that this information may be sent via fax machine.

All information I authorize to be obtained from the releasing person/institution will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

_____ 90 days _____ upon discharge _____ (specify date)

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

Client Signature _____ Date _____

Parent/Legal Guardian _____ Date _____

Witness _____ Date _____

I withdraw my consent to the release of information _____

Signature and date