



AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

Name _____

Date of Birth _____

I, _____ give my permission for release and exchange of information and records between White Tulip and the following:

Name	Address/Agency	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

The information released will include diagnosis, summary of psychological and psychiatric history and treatments, results of psychological testing and educational assessments, medical information, treatment plan and prognosis, and on-site consultations and observations.

Signature _____ Date _____