CONSENT TO RELEASE INFORMATION

Client Name: _____ DOB: _____

I authorize

Michelle Einson, PsyD/ The STEPP Program
14551 Adair Manor Court
Charlotte, NC 28277
Phone: 980-299-1234
Email: Dr.Einson@gmail.com

To release and/or obtain confidential information concerning my child _____ from the following agencies and/or individuals:

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

Name: _____
Address: _____
Phone: _____

I authorize

- ◯ Verbal communication regarding ALL clinician records/information between both parties
- ◯ Copies of all documentation to be mailed to Dr. Einson including:
  - ◯ School Records
  - ◯ Behavioral Assessments
  - ◯ Psychiatric Evaluations
  - ◯ Therapy records
  - ◯ Court records
  - ◯ Medical Records

I understand that I may refuse to sign this Authorization and that my refusal will not affect my ability to obtain treatment from Michelle Einson, PsyD or other colleagues of The STEPP Program.

I understand that this Authorization form can be changed or cancelled at any time without inhibiting treatment for my child.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date