NURTURE CHILD & FAMILY THERAPY CENTER

Authorization for Release of Confidential Information

I authorize Dr. Meltem Paker to release/receive/exchange information regarding my child:

Name: _____ DOB: _____

with the following person(s):

1.
2.
3.
4.
5.
6.

for the purpose of:

____ Evaluation/assessment and/or coordinating treatment efforts and educational interventions

____Other (specify) _____

This authorization permits the exchange of the following information:

____All information necessary

____Other (specify) _____

Expiration: One year after date below.

I understand that, upon my request, I may receive a copy of this release. I further understand the above consent can be withdrawn by me, in writing, at any time.

_____

Signature of Client/Parent/Guardian Date