CONSENT FOR RELEASE OF INFORMATION

List any professionals who may have worked with the Participant and/or family and sign the release form so we may communicate with them. If the Participant has attended a treatment center, hospital, or other program, include this information. Attach a separate sheet for additional listings if necessary.

Psychologists, Medical Doctors, Educational Counselors or Therapists:

Name ____

Nature of Service ____

Address ____

Telephone (____) ______________________ Dates From – To ___________________________

Name ____

Nature of Service ____

Address ____

Telephone (____) ______________________ Dates From – To ___________________________

Boarding Schools, Foster Homes, Hospitals, Treatment Centers or Other Inpatient Programs:

Program Attended ____

Address ____

Telephone (____) ______________________ Dates From – To ___________________________

Program Attended ____

Address ____

Telephone (____) ______________________ Dates From – To ___________________________

CONSENT FOR RELEASE OF INFORMATION TO GALENA RIDGE

We, the Undersigned, hereby authorize psychologists, medical doctors, counselors, therapists, hospitals, treatment programs or others who have counseled or treated ______________________________ to release any and all information regarding medical or therapeutic history, diagnosis, and treatment to the staff of Galena Ridge.

____ ____

Parent/Guardian Signature Date Parent/Guardian Signature Date