



AUTHORIZATION FOR RELEASE OF INFORMATION

Youth's Name: _____ Date of Birth: _____

I hereby authorize and request the release of my information to the person/organization listed below. All information obtained from this agency will be held strictly confidential and cannot be released without my written consent.

Person / Organization providing the information:

Person / Organization receiving the information:

Information is to be used for the purpose of: _____

Specific description of the information, including date(s): _____

I understand that this authorization will remain in effect for:

- Ninety (90) days
- One (1) year
- Other expiration date: _____
(month / day / year)

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

This form must be COMPLETE before signing.

Youth's Signature *Date*

Parent / Legal Guardian's Signature *Date*
(if youth is under 18 years old)

Witness Signature *Date*

USE THIS SPACE ONLY TO WITHDRAW CONSENT

Signature of Youth or Parent/Legal Guardian *Date*

Date consent is revoked