
Patient's Name _____ / / _____
Date of Birth

Parent/Guardian Name _____

I authorize The Madison Center and Therapeutic Frameworks to release and/or obtain information about the above patient, from the list below.

primary care physician

Name _____ Title _____

Organization _____ Phone _____ Email _____

insurance company

Name _____ Title _____

Organization _____ Phone _____ Email _____

school district/teacher

Name _____ Title _____

Organization _____ Phone _____ Email _____

other

Name _____ Title _____

Organization _____ Phone _____ Email _____

information to be released — *goals/objectives, progress, observations, recommendations.*

I give permission for The Madison Center and Therapeutic Frameworks staff to communicate using electronic mail with the above person(s) and/ or myself regarding my child. I understand that this authorization takes effect the day that I sign it.

It expires on _____ / _____ / _____ or no more than one year from the date of my signature.

I also understand that I may change this authorization at any time.

Signature of Parent/Legal Guardian _____ / / _____
Date