CONSENT FOR RELEASE OF PROESSIONAL INFORMATION

CHILD'S NAME: ______________________ DATE OF BIRTH: ___________

PARENT/GUARDIAN: __________________ DATE: ____________________

I (we) authorize and request the following individuals to release confidential information from professional contacts to the selections committee and treatment team at SULAM. I also authorize SULAM staff to share relevant information with the individuals listed below. I understand that the information will be used for professional purposes only.

Pediatrician: Name: ______________________ Address: ____________________ __________________________ __________________________ Phone: ______________________	***Psychiatrist:*** Name: ______________________ Address: ____________________ __________________________ __________________________ Phone: ______________________
Previous School/ Placements: Name: ______________________ Address: ____________________ __________________________ __________________________ Phone: ______________________	***Family Therapist:*** Name: ______________________ Address: ____________________ __________________________ __________________________ Phone: ______________________
Therapist (Current or Past): Name: ______________________ Address: ____________________ __________________________ __________________________ Phone: ______________________	***Other:*** Name: ______________________ Address: ____________________ __________________________ __________________________ Phone: ______________________

When and if a new professional becomes involved, I will inform the teacher or psychologist and add their name to the list of approved contacts.

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Parent's Signature ***(date)***