**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

**I Authorize:**

Name/Agency:

Address:

Phone: Fax:

To: ( ) Disclose information to: ( **X** ) Exchange information with:

**Kristin Woulfe, M.A.; 475 Cleveland Avenue N, Suite 220, St. Paul, MN 55104; Phone: 651-414-1080**

Regarding Client’s Name: Date of Birth:

Approximate Date(s) of Services:

**Information to be released:**

Written summary of professional’s records

School records, including all transcripts, attendance records, assessments, IEP’s, etc.

Medical records

Hospitalization records

Psychological diagnoses and treatment information

Psychiatric treatment information, including diagnoses and prescribed medications

Chemical dependency treatment records

X Progress notes

Discharge summary

Legal history and records

X Other (specify) Contact with therapist

**This authorization is given for purposes of** Parenting Consulting  **.**

I understand that once information is released pursuant to this authorization, it will become part of Kristin Woulfe’s, M.A., Parenting Consulting file and she cannot prevent re-disclosure of the information to another third party. I understand that I may revoke this authorization in writing to the address noted above. Upon fulfillment of the above stated purpose or the lapse of twelve months from the date of my signature, whichever comes first, this authorization will automatically expire without my expressed revocation. A photocopy or facsimile of this authorization is as valid as the original bearing my signature.

Signature Signature

Date Date

Print Name Print Name