

## Authorization for Release and/or Request for Information

I, \_\_\_\_\_, understand that no information regarding the psychological care  
Parent or Legal Guardian

of \_\_\_\_\_ D.O.B. \_\_\_\_\_ will be released/requested without my  
Child

signed consent. With this understanding, I am giving Nicole C. Campanella permission to engage in verbal and/or written communication in order to request/release the following information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

for the purpose of \_\_\_\_\_

Name of Agency/Person	Contact Information Address – Phone – Fax	Relationship to Patient

**All information I authorize to be released or requested will be held strictly confidential and cannot be released by the recipient without an additional written consent. I understand this authorization will expire six (6) months after the date signed, or on \_\_\_\_\_, 20\_\_\_\_, whichever is earlier. A copy of this authorization is valid in lieu of the original. I further understand I may withdraw my consent at any time.**

\_\_\_\_\_  
Print Name of Parent or Legal Guardian

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Nicole C. Campanella Ed.S., LLC  
Licensed School Psychologist SS983

**(Use This Space If Consent Is Withdrawn)**

\_\_\_\_\_  
Date Consent is Withdrawn

\_\_\_\_\_  
Signature of Parent or Legal Guardian