Authorization for Release of Information

When completed and signed, this form authorizes Free Spirit to release protected information from your clinical record to the person you designate.

Part I	Authorizing Person Information
First Name	Last Name
Address	Phone number

I authorize Free Spirit staff to release or obtain information with the following agency, school, or person.

Part II	Authorized Agency or individual
Name of Agency	Contact Person
Address	Phone number
Name of Agency	Contact Person
Address	Phone number
Name of Agency	Contact Person
Address	Phone number

Please. Describe, as detailed as possible, the information that you want to be disclosed.

_____

I am allowing Free Spirit to release or obtain this information for the following reasons: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

_____

Part III	Expiration

This authorization shall remain in effect until
◯ Fill in expiration date
◯ Event that relates to the individual or the purpose of the use or disclosure

Signature of Legal Guardian	Printed name and relationship to client	Date