Authorization For Two-Way Release of Information

Concerning A Minor

I hearby authorize a two-way release of psychological, medical, and educational information between

____

Psychotherapist, Tricia K. Buttkus, LCSW

And____

(Name and Title)

Re:____

(Name of Minor)

A photocopy of this authorization shall be equivalent to the original.

This authorization can be revoked by me at any time except to the extent that action has been taken in reliance thereon. I understand that such revocation must be in writing and delivered to all the above named professionals. If not earlier revoked by me, this authorization shall automatically terminate one year after treatment has been completed and professional fees have been paid in full.

____________________ ____________________ ____________________

(Date) **(Minors Birth Date)** **(Signature of Parent or Guardian)**