Schachner Associates, P.C.

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Consent to Release ☐ and/or Obtain ☐ Information

_____ _____
Client Name **Date of Birth**

I, (or on my child's behalf), hereby authorize **Schachner Associates**, 128 North Craig Street, Suite 210, Pittsburgh, PA 15213, to:

☐ ***release*** information and records for the purpose of evaluation and treatment to:

☐ ***obtain*** information and records for the purpose of evaluation and treatment from:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

The following records are to be released ____**in writing** ___**verbally** ____**in writing and verbally** ____**via fax:**

___Psychiatric
___Medical
___Psychological
___Report Cards/Anecdotal Notes
___Standardized Test Scores
___Comprehensive Evaluation Report
___Individualized Educational Program
___Speech/Language
___Occupational Therapy
___Physical Therapy
___Neurological Evaluation
___Counseling/Psychotherapy
___Other (*Specify*)_____

Information related to HIV and drug/alcohol evaluation and/or treatment will be released unless otherwise indicated: ____ **Do not release information regarding HIV status or alcohol/drug evaluation/treatment.**

I understand that, in order to protect the limited confidentiality of my records, my permission to obtain or release information is necessary. I also understand that I may withdraw my consent at any time, except for actions that have already been taken. This release is effective for one year from the date the form is signed unless otherwise specified.

_____ _____
Client (14 and Older) **Date**

_____ _____
Parent/Guardian **Date**

_____ _____
Witness **Date**