

**Family Link Consent to Disclosure/Release of Client Record Information**

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_

This form authorizes Family Link staff to obtain from and/or release to any medical care provider, school personnel or other professional staff member, information for/from the records of the above named client.

The information to be obtained/disclosed may include:

- Initial Evaluation/History
- Psychiatric/Psychological Reports
- Medical Information
- School Records
- Transfer/Termination Summary
- Other \_\_\_\_\_

TO WITHHOLD ANY OF THE TYPES OF INFORMATION ABOVE, YOU MUST CROSS OUT THAT TYPE OF INFORMATION.

IF NO INFORMATION ABOVE IS CROSSED OUT, THIS DOCUMENT SHALL BE CONSTRUED AND INTERPRETED AS A GENERAL RELEASE FOR FAMILY LINK STAFF TO OBTAIN/RELEASE INFORMATION FOR THE PURPOSE(S) OR NEED(S) OF THE ABOVE-NAMED CHILD FOR PROFESSIONAL USE ONLY AND TO MEET THE NEEDS THAT ARE IN THE BEST INTERESTS OF THE CHILD.

This consent may be revoked at any time by notifying Family Link in writing. It may also be revoked by specifying a date, time, event or condition upon which your consent will expire (if so, specify here) \_\_\_\_\_

Unless otherwise stated, this consent will be valid until termination of current placement.

My signature indicates that I understand and agree to the contents of this form.

\_\_\_\_\_  
Signature of Child – age 5 and over must sign (under 5 write “too young”) Date

\_\_\_\_\_  
Signature of Family Link Staff Member Date

\_\_\_\_\_  
Signature of Managing Conservator/Foster Parent Caregiver/Guardian Date