



**Permission to Obtain/Release Confidential Information**

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

I hereby give consent to Sunshine State Counseling Center to exchange pertinent and relevant information with the individual/agency identified below.

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Information obtained may include (check all that apply):

- Clinical Impressions and Records
- Academic Records (cumulative records, report cards, standardized test scores, etc.)
- Health Records
- Special Education Records/504 Plan Records (IEP, 504 Plans, PPT/Student Study Team minutes, evaluations)
- Psychiatric Evaluations
- Psychological Evaluations
- Social Work Evaluations
- Educational Evaluations
- Speech and Language Evaluations
- Other Evaluations (vocational, occupational, etc.)
- Other \_\_\_\_\_

Client/Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Date: \_\_\_\_\_