

**CONSENT FOR RELEASE OF PROFESSIONAL INFORMATION**

**CHILD'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**PARENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

I (we) authorize and request the following individuals to release confidential information from professional contacts to the selections committee and treatment team at SULAM. I also authorize SULAM staff to share relevant information with the individuals listed below. I understand that the information will be used for professional purposes only.

<b><i>Pediatrician:</i></b> Name: _____ Address: _____ _____ _____ Phone: _____	<b><i>Psychiatrist:</i></b> Name: _____ Address: _____ _____ _____ Phone: _____
<b><i>Previous School/ Placements:</i></b> Name: _____ Address: _____ _____ _____ Phone: _____	<b><i>Family Therapist:</i></b> Name: _____ Address: _____ _____ _____ Phone: _____
<b><i>Therapist (Current or Past):</i></b> Name: _____ Address: _____ _____ _____ Phone: _____	<b><i>Other:</i></b> Name: _____ Address: _____ _____ _____ Phone: _____

When and if a new professional becomes involved, I will inform the teacher or psychologist and add their name to the list of approved contacts.

\_\_\_\_\_  
*Parent's Signature*

\_\_\_\_\_  
*(date)*