



800 Oak Avenue Wyoming OH 45215 (513) 821-2428

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____

Client's Birthdate: _____

Client's Address: _____

Client's Telephone Number: _____

I, the undersigned, hereby authorize Wyoming Youth Services Bureau to release any and all information and records or copies of records relating to the history, treatment, counseling and other services rendered to _____, a minor, in connection with any condition, disease or ailment for which counseling is now or heretofore been required.

The following records may be released:

The above information is to be released to/from:

Name and Title: _____

Name of Agency: _____

Street Address: _____

City, State and Zip Code: _____

This authorization is valid for ninety (90) days. I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the release of records.

Parent/Guardian Signature

Date

Witnessed by: _____