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CONSENT TO RELEASE OR OBTAIN INFORMATION

I, _____, hereby authorize Dr. Deborah Cole :

to RELEASE information to:	to OBTAIN information from:
_____	_____
_____	_____
_____	_____
_____	_____

The extent or nature of the information to be released is:__**oral communication,**

____**medical and** _____**psychiatric and** _____**psychological**

____**and educational and** _____**social information**_____

RE: _____

The purpose of releasing or obtaining this information is:__**to coordinate care**
or _____

I understand that I may revoke this authorization at any time by either oral or written request, except to the extent that action will have been taken on information obtained prior to revoking my consent. Otherwise, this consent is valid for twelve (12) months from the date of signature.

I have read all of the above and understand the nature of this release.

_____	_____
Signature of Client or Guardian	Date
_____	_____
Signature of Witness	Date
_____	_____
Signature of Minor for Assent	Date