Aileen Hays, LCSW
800 Highway 290, Building D, Suite 400
Dripping Springs, TX 78620
512-829-1424

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, give full authorization to Aileen Hays,LCSW

to provide/exchange information regarding the mental health information of

_____ (name of minor child) to/with:

Name: _____

Address: _____

City, State, Zip _____

Phone: _____

for the purpose of

_____

_____

_____

This consent is subject to revocation by the undersigned, and remains in force indefinitely from the date of signature unless revoked in writing by undersigned.

By signing and dating this release of information, I allow the person listed above to share specific record information with Aileen Hays, LCSW.

_____
Printed Name of Parent or Guardian

_____
Signature of Parent or Guardian

_____
Date

_____
Witness signature