EARLY CHILDHOOD MENTAL HEALTH SERVICES

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480-345-0817 (OFFICE)
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TWO-WAY EXCHANGE OF INFORMATION

I hereby authorize Dr. Toni Hembree-Kigin and _____

_____

(enter name/address of pediatrician, school district, etc.)

to exchange, or release to each other, psychological testing, therapy, medical and educational information concerning my child:

Name_____ DOB_____

Address_____

_____

_____ _____

Legal Guardian Signature Relationship to Client

_____ _____

Date of Signature Witness

This consent may be ended at any time by the child's guardian (ending the consent will not cancel any action that has already been taken as allowed by the form). Unless the parent wishes to cancel this consent at an earlier time, it will automatically stop upon the date, and/or event, and/or condition indicated below. If the following lines are left blank, the consent will remain in effect indefinitely.

_____ _____

Event/Condition Date

Note to Party Receiving Information: This information has been disclosed to you from confidential records, which are protected by federal law prohibiting you from making any further disclosure of this information without the specific consent of the person to whom it pertains (or that person's legal guardian), or is otherwise permitted by such regulations.