



Release of Information Form A

To: Name: _____

Address: _____

I, _____, *parent/guardian* of
_____ (*child*)

Authorize you to speak with _____ (child's) provisional psychologist,
Heather McAuliffe, at Child Development Network, Milton and release information
about them that might be helpful regarding their care and ongoing treatment.

I also authorize and request that you release copies of my records concerning:

Please forward this information to Heather McAuliffe at the contact details included in
this form.

I have read and understood the above information. I agree to these conditions for the
service provided by Heather McAuliffe.

Child's Name

Name of Parent/Caregiver

Signature

Date