JAMES W. CARON, ED.D., CGP
CONNECTIONS CHILD AND ADOLESCENT GROUP PROGRAM

AUTHORIZATION FOR RELEASE OF INFORMATION

AUTHORIZATION TO RECEIVE and/or RELEASE INFORMATION REGARDING:
(circle above)

_____
name of client

_____
date of birth

A separate release form will be needed for each provider. Please specify by **circling** if this release is for school personnel, pediatrician, current psychotherapist, psychopharmacologist or prescribing physician, former psychotherapist, or other: _____

This release is for the following provider:

Name_____

Street address _____

City/State/Zipcode _____

Phone_____

Contact person: _____

The information to be disclosed is:_____

_____

_____

The purpose of this release is:_____

_____

_____

Client's signature:_____

Date of signature:_____

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