Milestones in the Making
Schiavoni & Associates, Inc.

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AUTHORIZATION TO RELEASE/RECEIVE CLIENT INFORMATION]

(YOU ONLY NEED TO COMPLETE THIS IF YOU WOULD LIKE TO GIVE PERMISSION TO MS. SCHIAVONI SPEAK WITH A TEACHER, DOCTOR, ETC. OR SEND A COPY OF THE EVALUATION REPORT TO A PARTY YOU SPECIFY ON THE FORM)

I hereby consent for Milestones in the Making, Schiavoni and Associates, Inc.
To release/receive pertinent information regarding the following client:

_____ _____

Client's Full Name **Date of Birth**

To/from the following persons/agencies/teachers/counselors/doctors/school but not limited to:

Agency Name:_____ Contact Person:_____

Address:_____ Phone #: _____

_____

Fax #:_____

Agency Name:_____ Contact Person:_____

Address:_____ Phone #: _____

_____

Fax #:_____

Information Type: The following Checked Items are being: Released____ Requested____

__Assessment __Psychological Evaluations __Continuing Care Plan

__Diagnosis __Medication Management Info. __Discharge/Transfer Summary

__Treatment Plan/Summary __Demographic Information __Legal/Criminal Justice Info.

__Medical Information __Other_____

I understand that this authorization is subject to revocation at any time, except to the extent that Milestones in the Making, Schiavoni & Associates Inc has already taken action on this authorization. If not revoked earlier by written notice to Milestones in the Making, this authorization will expire as follows:

Check one:____ One year from date of signature below

____Upon reaching(Specific date, event or condition)_____

Once the requested information is disclosed pursuant to this authorization,Milestones in the Making will no longer have control over the information, and there is a potential that it may be re-discolsed by the recepient and will no longer be protected by the privacy under the Health Insurance Portability and Accountability Act(HIPPA.)

_____ _____ _____

Parent/Guardian Signature Date Client Signature(if applicable)