



# YOUTH FOR TOMORROW

## AUTHORIZATION FOR THE RELEASE OF INFORMATION

**Child/Referral Full Name** \_\_\_\_\_  
Last First Middle Suffix(Jr. II. Etc)  
\_\_\_\_\_  
Age Date of Birth Social Security Number

**The child/referral listed above is/will be a resident of the Youth for Tomorrow New Life Center, located at: 11835 Hazel Circle Drive in Bristow, Virginia.**

*I hereby, give Youth for Tomorrow my permission to obtain the requested information from each of the below listed component organizations that maintain records on this child/referral. I have been informed of the type of information that will be required in the course of providing care, the benefits and/or disadvantages of releasing this information, and that substance abuse information may be contained in the requested reports. I authorize both written and verbal exchange of information.*

***Please mark ("X") all that apply***

<u>Educational Information</u>	<u>Medical Information</u>	<u>Counseling Information</u>
_____ Current Grade Cards	_____ Medical History	_____ Psychiatric Evaluations
_____ Transcripts	_____ Discharge Summaries	_____ Psychiatric History
_____ Educational Evaluations	_____ Other:	_____ Progress Notes
_____ Current IEP		_____ Psychological Testing
_____ Other:		_____ Discharge Summaries

*I understand that the provision of services is not contingent on the release of this information. I voluntarily consent to the release of the requested information.*

\_\_\_\_\_  
**Print Name of Parent/Legal Guardian**

\_\_\_\_\_  
**Parent/Legal Guardian Signature**

\_\_\_\_\_  
**Date**