

*K12 Psycho-Educational Services, LLC*  
*Comprehensive Evaluations for Children and Adolescents*

**Authorization for Release of Information**

Name of Client: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I request and authorize:      Tonya Klem, Ed. S.

To obtain from or exchange with: \_\_\_\_\_  
(Name and Address)

\_\_\_\_\_  
\_\_\_\_\_

the following information:

- |  |  |
|--|--|
| <input type="checkbox"/> Academic Records                  | <input type="checkbox"/> Teacher Interview |
| <input type="checkbox"/> Psychological Testing             | <input type="checkbox"/> Medical History   |
| <input type="checkbox"/> Other: Other info to be obtained. |  |

for the purpose(s) of: \_\_\_\_\_

All information I hereby authorize to be obtained from this person or agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that I have the right to inspect and receive a copy of the material to be disclosed. I understand that this authorization will remain in effect for 90 days unless I specify an earlier expiration date here: *Earlier Date*. I may revoke this authorization at any time except to the extent that information already released pursuant to this consent cannot be recalled.

\_\_\_\_\_  
Signature of Client or Guardian

\_\_\_\_\_  
Date

IF PATIENT WITHDRAWS CONSENT

\_\_\_\_\_  
Signature of Client (withdrawn consent before 90 days)

\_\_\_\_\_  
Date