NEW CHAPTER
CONSULTING
Educational and Therapeutic Options

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REQUEST FOR AND RELEASE OF INFORMATION

STUDENT'S NAME:

DOB: AGE: SSN: - - CITIZEN OF:

NAME OF DOCTOR/PROVIDER:

NAME OF FACILITY:

ADDRESS:

CITY: STATE: POSTAL CODE: COUNTRY:

PHONE : FAX:

CARE WAS RECEIVED ON (APPROXIMATE DATES OF SERVICE):

I authorize New Chapter Consulting to exchange pertinent information, both written and verbal to schools and programs for the purpose of determining appropriateness of placement.

_____ _____

SIGNATURE OF CLIENT DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

This authorization will remain in effect for one year from the above date.