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## AUTHORIZATION TO EXCHANGE INFORMATION

To maximize the effectiveness of our evaluations, we would like to have the ability to contact other professionals working with you.

I hereby authorize:

Doctor: \_\_\_\_\_  
Name/Telephone/Fax

Therapist/Psychologist: \_\_\_\_\_  
Name/Telephone/Fax

School (Teacher, School Psychologist): \_\_\_\_\_  
\_\_\_\_\_  
Name/Telephone/Fax

Other: \_\_\_\_\_  
Name/Telephone/Fax

To release and/or exchange any or all pertinent information relating to

\_\_\_\_\_ to the Morrissey-Compton Educational Center  
Client Name

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date