BUCKS ESC
Eating Support Collaborative

RELEASE OF INFORMATION

I, _____ hereby authorize BUCKS ESC @ Newtown Therapy to release and exchange information pertaining to my child's evaluation and therapy sessions to:

_____

_____

I understand that authorization shall remain valid from the date of my signature below and for 9 months thereafter. I have been informed that I may revoke this authorization by written or oral communication to BUCKS ESC @ Newtown Therapy. I certify that this form has been fully explained to me and that I understand its contents.

_____
Name of Minor Child Client

_____ _____
Signature of Parent / Guardian Date of Authorization