1575 Savannah Highway – Suite 6
Charleston, SC 29407
(843) 266-1318
(843) 266-1941 FAX
www.frcdsn.org

Parent Training and Resource Center

RELEASE OF INFORMATION

I, ____,
(Parent, Guardian or Client if over 17 years of age)

do hereby grant any staff of the Parent Training and Resource Center authorization to examine and/or obtain photocopies of any and all educational, psychological, medical, social, psychiatric or any other records of:

(Child's Name)____.

(Child's Date of Birth) ____________________________________

I also authorize any staff of the Parent Training and Resource Center to engage in verbal discussion regarding relevant information pertaining to this child. I also acknowledge that a photocopy of this signed authorization shall be as valid as the original.

_____________________________ (Signature)

_________________________ (Date)

Witness: ______________________________