AUTHORIZATION FOR RELEASE OF INFORMATION:

School, Other Agency, Other Treatment Provider
(make a copy of this form for each place or provider)

I authorize ___________________________ and:

Provider name: **Argosy University, San Francisco Bay Area Campus**

Address: 999-A Canal Blvd.
Point Richmond, CA 94804

Phone: 510 215-0277
Fax: 510 215-0299

to exchange information about:

Name: ______________________________ Birthdate: _________________

Including, but not limited to medical records, lab results, psychological testing, medication records, school reports, etc. This information is to be used solely for the purpose of evaluation/diagnostic workup/treatment planning/preparing court report/treatment, other:
____

This authorization has the following exceptions:______________________________
This authorization is valid for _______________________time from the date signed.

____________________________________ ______________________
Signature (patient) Date

____________________________________ ______________________
Signature (parent or guardian) Date

____________________________________ ______________________
Signature (parent or guardian) Date

*Note: If divorced or separated parents with custody difficulties, both signatures will be needed please.