CONSENT FOR RELEASE OF INFORMATION

This form grants Rebecca L. Soffer, PsyD and Preschool Psychology the permission to speak to _____.
My child's legal name is _____.
and DOB is _____. Home address is the following:
_____.

The purpose of this consent is to grant Dr. Rebecca L. Soffer and Preschool Psychology the permission to discuss elements of my and my child's treatment, so as to further assist his progress. This consent is valid for 90 days following the date of my signature on this form. I understand that my consent is voluntary and that I may withdraw this consent by written request to Preschool Psychology at any time, except to the extent that it has already been acted upon.

My signature below indicates I have read and understand this consent form, and that I voluntarily allow Rebecca L. Soffer the permission to speak to the aforementioned person or party. The purpose of this form has been explained and I have had my questions answered prior to signing this informed consent.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date