



NOTE: Please check all that apply and complete. Thanks!
(MUST INCLUDE PHONE NUMBERS)



I, _____, authorize Perspectives staff to obtain/release my records or my children's records, or to discuss my situation in regards to my or my children's participation in Perspectives programs with the following: All medical, educational, employment, penal, or rehabilitative people or agencies which may be helpful in addressing my or my children's needs:

- Child Protection
Name _____ Phone # _____
- Parole or Probation Officer
Name _____ Phone # _____
- Therapist/Counselor
Name _____ Phone # _____
- Children's Therapist/Counselor
Name _____ Phone # _____
- Guardian At Litem
Name _____ Phone # _____
- Aftercare Counselor
Name _____ Phone # _____
- Foster Care Parents
Name _____ Phone # _____
- Social Workers
Name _____ Phone # _____
- Children's School District(s)
Name _____ Phone # _____
- Chemical Dependency Treatment Center
Name _____ Phone # _____

- Psychiatrist
Name _____ Phone # _____

- Doctor/Physician
Name _____ Phone # _____

- Employment Counselor
Name _____ Phone # _____

This 2-way release will be effective for **One Year** from the date signed. I understand I may revoke this release at any time, which may affect my participation in Perspectives Programs.

Parent/Guardian's Signature Date

Staff Witness Signature Date