Edgewood Children's Center
330 North Gore Avenue
St. Louis, Missouri 63119
Voice 314-968-2060
Fax 314-968-2375

AUTHORIZATION TO OBTAIN INFORMATION

To: ____

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Information Regarding ______________________________ Sex _____ Birthday ______________

____
Street City State Zip Code

Purpose of the information ____

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Please send the information to Edgewood, in care of ______________________________

in the ____ Program.

Information Requested:

Do Not Release	Release	
___	___	Medical Records
___	___	School Records of Medical, Social, Psychological, and Academic Status
___	___	Psychiatric Evaluation
___	___	Psychological Testing
___	___	Social History
___	___	Diagnosis, Treatment Plan, and Treatment Progress
___	___	Other ____

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I authorize and request that the above named person or agency release and provide the following information to Edgewood Children's Center. I understand that I may withdraw this authorization at any time.

___ One Time Authorization: Beginning ____________________ Ending (not to exceed 90 days) ____________________

___ This authorization remains valid during the time the child named below is receiving treatment from Edgewood. Beginning ____________________ Ending (not to exceed 1 year) ____________________

____________________ ______________________________ ____________________
Date Signature Relationship To Client

____________________ ______________________________ Witness
Date Signature , Degree, Title