EPSTEIN EDUCATION
Lisa Soll Epstein
epsteined@gmail.com
415-722-2046

Authorization to Release Information

To: _____

Address:
_____
_____

Please indicate 1 or 2 or both: _____

1. I hereby authorize the release of requested information, including educational, speech/language, psychological, and health data, contained in your records on my child, _____ , birth date _____, to Lisa Soll Epstein.

2. I hereby authorize Lisa Soll Epstein to provide information to the above stated person(s) or agency(cie), in writing upon request, or in the process of consultation, regarding assessment and treatment of my child, adolescent, or young adult,

_____
(Full Name)

_____
Parent signature

_____
Print name

_____
Date