COBC℠
central ohio behavioral consulting

Authorization to Receive Information

Date: _____

I hereby authorize the following individuals and/or agencies to releaseand discuss information from the records of my child _____, to Lindsay R. Sessor, M.A., BCBA and/or Leigh Ann M. Shepherd, M.A., BCBA, at Central Ohio Behavioral Consulting, LLC.

1. _____
(Individual/Agency)

_____
(Address) (Phone number)

2. _____
(Individual/Agency)

_____
(Address) (Phone number)

3. _____
(Individual/Agency)

_____
(Address) (Phone number)

4. _____
(Individual/Agency)

_____
(Address) (Phone number)

5. _____
(Individual/Agency)

_____
(Address) (Phone number)

Subject to the following limitations and exclusions:

_____
_____
_____
_____
_____

I understand that I may revoke this consent at any time by informing the above parties in writing.

_____ _____
Client signature (ifappropriate) Date

_____ _____
Signatureof Parent or Guardian Date

_____ _____
Signatureof Parent or Guardian Date

_____ _____
Signature of Witness Date

This release of information remains in effect for one year from the date of signature unless otherwise notified.