

Authorization to Receive Information

Date: _			
		s and/or agencies to release and discu	
records	s of my child		
to Lind	say R. Sessor, M.A., BCBA and/or Le	igh Ann M. Shepherd, M.A., BCBA, at (Central Ohio Behavioral
Consul	ting, LLC.		
1.			
1.		(Individual/Agency)	
	(Address)		(Phone number)
2.		(Individual/Agency)	
		(marvidual) 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	ng the above parties in writing.
Client signature (if appropriate)	 Date
Signature of Parent or Guardian	 Date
Signature of 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.