EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

610-455-4040
855-251-8777
info@ebsciwc.com
www.ebsciwc.com
200 Skiles Blvd. | West Chester, PA 19382

Consent to Release/Obtain Information

I, the parent/guardian, _____, authorize and request EBS Children's Institute of West Chester to RELEASE TO and OBTAIN Information and DOCUMENTATION FROM the record to the individual identified below for therapeutic purposes including collaboration, planning and treatment:

Start Date of Services:_____ End date of Services:_____

Information being released includes (please circle all that apply):

Evaluation and Assessment	Diagnosis	Behavioral Plan
Progress Report	In School Plan	Other:_____
Daily Notes	Treatment Plan	All

Consent given: _____Verbal Consent _____Written Consent

Childs Name_____ DOB_____

I authorize information and documentation to be released to:

Name of Individual Agency Relationship

Phone Number

Parent/Guardian Signature Relationship Date

Witness Relationship Date