662-380-5170
662-380-5271
info@ebscioxford.com
www.ebscioxford.com
104 Skyline Drive | Oxford, MS 38655

Consent to Release/Obtain Information

I, the parent/guardian, ______________________________, do hereby authorize EBS Children's Institute of Oxford to RELEASE TO and OBTAIN INFORMATION AND DOCUMENTATION FROM the record of the individual identified below for therapeutic purposes including collaboration, planning and treatment:

____ ______________________

Child's Name Child's DOB

I authorize information and documentation to be shared with:
(i.e. pediatrician, school staff, outside therapists, etc.)

____ ____

Name of Individual Name of Agency

____ ____

Phone Number Fax Number

____ ____

Name of Individual Name of Agency

____ ____

Phone Number Fax Number

____ ____________________

Parent/Guardian Signature Relationship Date

We Care More. We Do More.