BUCKS SUPPORT SERVICES

17 BARCLAY STREET, NEWTOWN, PA 18940

RELEASE OF INFORMATION FOR MINORS

I, _____, hereby authorize Bucks Support Services to release and exchange information pertaining to my child's evaluation and therapy sessions to:

_____

_____

_____

I understand that authorization shall remain valid from the date of my signature below and for 12 months thereafter. I have been informed that I may revoke this authorization by written or email communication to Bucks Support Services. I certify that this form has been fully explained to me and that I understand the content.

_____

Child's Name

_____ _____

Signature Date of Authorization