

# MARK S. TRUSTIN

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## AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF INFORMATION

I, \_\_\_\_\_, hereby request and authorize

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_

3. \_\_\_\_\_ Date: \_\_\_\_\_

4. \_\_\_\_\_ Date: \_\_\_\_\_

5. \_\_\_\_\_ Date: \_\_\_\_\_

6. \_\_\_\_\_ Date: \_\_\_\_\_

7. \_\_\_\_\_ Date: \_\_\_\_\_

8. \_\_\_\_\_ Date: \_\_\_\_\_

and its appropriate representatives and keepers of the records to release any and all information concerning \_\_\_\_\_ and his/her educational experience, without limitation, to **Mark S. Trustin, Attorney at Law** 221 Deer Chase Ln., Durham, North Carolina 27705. The extent and nature of this information to be disclosed shall include the following:

|                          |                                     |                          |                          |
|--------------------------|-------------------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | Summary of Evaluation and Treatment | <input type="checkbox"/> | Medication History       |
| <input type="checkbox"/> | Intake Information                  | <input type="checkbox"/> | Psychological Evaluation |
| <input type="checkbox"/> | Progress Notes                      | <input type="checkbox"/> | School Attendance Record |
| <input type="checkbox"/> | Discharge Summary                   | <input type="checkbox"/> | School Conduct Record    |
| <input type="checkbox"/> | Psychiatric Evaluation and History  | <input type="checkbox"/> | Educational Information  |
| <input type="checkbox"/> | Treatment Plan and Diagnosis        | <input type="checkbox"/> | Other _____              |

I understand that I am not required to give my consent, however, I also realize that without my consent the services that could be offered to me may be limited. I understand that I may revoke this consent upon request at any time except to the extent that the information has already been released. Otherwise, this consent shall continue to be valid for as long as is reasonably necessary to carry out the services, or it will automatically expire 24 months after the date on which it is signed.

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

*A photocopy of this authorization shall be considered as effective as the original.*