



**Potential, Inc.**  
**638 Newtown Yardley Road**  
**Commons West, Suite 1F**  
**Newtown, PA 18940**  
**www.potentialinc.org**  
**888-AUTISM-0**

## Consent to Release Information

I, \_\_\_\_\_, allow Potential, Inc. to exchange information regarding my child, \_\_\_\_\_, with:

- Medical Personnel (including physicians, nurses, and physicians assistants)
- Psychological/Psychiatric Personnel (including current and past therapists/counselors, psychiatrists, wraparound and assessment providers)
- Educational Personnel (including current and past teachers, educational aides, special educators, school psychologists, or other educational professional)
- Agency Personnel (including current and past agencies who had contact with the child for the purpose of diagnosing, treating, evaluating, or consulting about the child's performance or diagnosis)

Limits to this release include (if none, indicate with N/A):

I understand that Potential, Inc. will keep information and documents confidential. I understand that this Consent to Release Information is valid for the period of time in which the above-named person is an active client. All or any part of the Consent for Release of Information is canceled upon receipt of written notification from the undersigned.

Signed:

\_\_\_\_\_

Parent or Guardian

\_\_\_\_\_

Date