



Selman Behavior Solutions

*Finding Solutions * Creating Change*

11 Broadway, STE 300
New York, NY 10004
(646) 360-0184

www.SBSolutionsNY.com

Consent for Release of Information

I, _____, authorize Selman Behavior Solutions, to discuss my child's
_____ (name of child) information and/or treatment with the following:

Name/Affiliation _____

Address _____ City _____

State _____ Zip _____

Phone Number _____ Fax Number _____

Email Address _____

This authorization will remain in effect until ____ / ____ / _____. If no expiration date is indicated, consent will expire one year from the date it is signed.

I understand that I have the right to revoke this authorization at any time by sending written notification to Selman Behavior Solutions at the above address.

By signing below, I authorize Selman Behavior Solutions to release information regarding the above patient's treatment to named party.

Patient/Guardian Signature _____ Date ____ / ____ / ____