Consent to Release Information

Disability Consulting and Training, LLC
Phone: 703-419-0694
Email: linn@disabilityconsultingtraining.com
Weblink: www.disabilityconsultingtraining

Client Name:________________________

I understand that Dr. Linn Jorgenson from Disability Consulting and Training (DCT) will have access to my medical/mental health records and other academic records. I further understand that in order to meet my educational and life goals, it may be necessary for Dr. Jorgenson to contact those connected to me as indicated below. I authorize the professional exchange of disability- related information for purposes of planning and providing quality services between (DCT) and the following (check all that apply):

- ☐ Current school (teachers/administrators)
- ☐ Family members
- ☐ Counseling, Mental Health Providers/Services
- ☐ After School Caretakers
- ☐ Community Providers
- ☐ Spiritual Advisor
- ☐ Employers
- ☐ Medical Health Services

Parent(s)/Legal Guardian:			
Client Signature:			
Medical Provider:			
Phone:		*Email:*	
Mental Health Provider:			
Phone:		*Email:*	
School Point of Contact:			
Phone:		*Email:*	
Other:			

Parent/ Guardian Signature:__________________________**Date:**__________________________

Client Signature: ________________________________**Date:** __________________________

Revised June 2018