AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

Name of Client: ____

Date of Birth: ____

I hereby authorize Milton D. Little to request, receive, review, and copy any information, oral or written, concerning the above-named individual, including, but not limited to, information concerning the physical, mental, and emotional health, condition, and well-being, and the educational experience and history of the individual. I consent to the disclosure of and mutual exchange of all such information to and from Milton D. Little. It is understood that this information will be shared with potential schools and programs also. This authorization and consent applies to, but is not limited to, information known by professionals, schools, programs and individuals and records contained in the medical, psychological, psychiatric, hospital, school, and institutional records of the following:

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Parent or Legal Guardian: ____
Address: ____
Date: ____
Parent or Legal Guardian: ____
Address: ____
Date: ____

Mail to: Dr. Milton D. Little
Burke-Little & Associates, Inc.
411 Morris Street
Durham, NC 27701

Phone: 919.688.5785 Fax: 919.287.2950
Cell: 919.622.0887 Email: burklittle@aol.com