Sparkman
Counseling & Educational Consulting
PLLC

CHILD/ADOLESCENT
CONSENT FOR COMMUNICATION

The following is a consent which allows *Laura Sparkman* to communicate with outside professionals working with your child/adolescent.

_____ _____
Name of Student Date of Birth (age)

_____ _____
Parent/Guardian Printed Name Phone Number

_____ _____
Parent/Guardian Signature Date

Information is only released with your signed authorization to release information.

I hearby give permission for the release of information between the following parties. *Laura Sparkman* is authorized to communicate according to this release:

Laura Sparkman	Licensed Professional Counselor	214-914-6519
Name	Position	Phone

Laura Sparkman has permission to communicate and exchange information with the school personnel or outside professional(s) listed below:

_____ _____
Name and Professional Relationship to Student Phone

_____ _____
Address Email

_____ _____
Name and Professional Relationship to Student Phone

_____ _____
Address Email

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