Danit Kaya, M.P.H, E.T. www.danitkaya.com 805.405.2301

Authorization for Release and Exchange of Confidential Information

I understand it may be important to have a confidential exchange of information between my educational therapy team and my/our child's support team (mental health professionals, medical professionals, school teachers, and/or educational supports).

For this purpose, I, _____
Parent(s) or Guardian(s) (print name(s))

give permission for the exchange of educational, social and medical information about my/our

child, _____
Child's name (print name)

between Danit Kaya, M.PH., E.T., Educational Therapist, Mindfulness and Executive Functioning Coach and the following professionals:

_____	_____
Outside Professional Name/Title	Phone and email:
_____	_____
Outside Professional Name/Title	Phone/email:
_____	_____
Outside Professional Name/Title	Phone/email:

I understand this authorization permits the exchange of any and all necessary information related to the purpose of supporting my/our child's academic progress and emotional well-being, including conversations and written information. I understand that I have a right to receive a copy of this authorization form. I also understand this authorization shall remain valid until my child's treatment ends with the professional and/or until it is revoked or modified in writing.

_____	_____	_____
Parent/Guardian Signature	Relationship	Date
_____	_____	_____
Parent/Guardian Signature	Relationship	Date