Healing Hands for ADHD
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AUTHORIZATION TO RELEASE/OBTAIN HEALTH AND EDUCATIONAL INFORMATION

Read the entire document before signing

Patient Name _____DOB: _____

1. I authorize the use or disclosure of the above-named individual's school information (written and verbal and by E-mail) reciprocally between the following Education organization and Dr. Linda Caballero at the Address Above.

2. The following educational organization is authorized to make this disclosure:
School: _____
Address: _____
_____
Phone: _____ Fax: _____

3. This release also gives permission for Dr. Caballero to attend any school meeting that are requested by Parent
4. The type of information to be used or disclosed (requested) is as follows:

School Records/Reports ____ Behavior Rating Scales ____ Verbal Communications ____
Medical letters or psychological Evaluations that pertain to education. ___ Other (Please give specific description) _____

School year ____2025 - 2026_____

I have read and understand this authorization and authorize the use and/or disclosure of the information as described in this authorization. I understand all interactions will be HIPPA Compliant. This authorization will remain in effect from the date signed above until revoked by the patient or personal representative of the patient.

_____ _____
Signature of Patient (or personal representative) Date

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient