AUTHORIZATION FOR RELEASE OF MEDICAL OR SOCIAL INFORMATION

We, the undersigned, do hereby grant consent to the release of information regarding _____,

obtained from medical doctors, attorneys, counselors, psychologists, psychiatrists, social workers, schools, and all social service organizations to:

Mid-Western Children's Home
P.O. Box 48
Pleasant Plain, Ohio 45162

Further, we authorize Mid-Western Children's Home to share information with these professionals and organizations for the purpose of coordinating service and securing treatment if and when needed.

_____
Signature of Parent, Guardian, or Caseworker

_____
Date