Release Authorization

Permission is hereby granted to *Dr. Milton Little* of *Burke-Little & Associates, Inc.* to release the
records, test scores, and any other pertinent educational, psychological, psychiatric or other medical information concerning

(name of student/client) ____

to any school, program, hospital or agency deemed necessary for educational and/or therapeutic counseling and placement. Receipt of this form will allow *Dr. Milton Little* to receive, review, and discuss the above-named student's/client's educational requirements with other professionals involved, as well as provide you with recommendations regarding possible placement opportunities.

It is understood that these reports, documents or discussions will be used only in the furtherance of determining current and future academic and/or therapeutic plans for the above student/client. Such information will remain confidential and shall be used in a manner to ensure the protection and safeguarding of all rights provided by law otherwise.

This authorization shall remain in effect until the student/client has matriculated in or transitioned to another school or therapeutic program or revoked by me in writing. A photocopy or facsimile of this authorization shall be as valid as the original.

____
Client's Signature if 18 years or older

____
Parent or Guardian Signature

____
Date Signed

____
Parent or Guardian Signature

Burke-Little & Associates, Inc.
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