



Therapist Release Form

Date: _____

Duration of Release: _____

To: _____

Address: _____

City Zip

Release for: _____
Student's Name

In order for us to serve you student in the most effective manner, we must have your understanding of and permission for frequent, ongoing written and oral communication exchange between your child's and/or family's therapist and Mill Springs Academy staff.

Permission granted by: _____
Print Name

Relationship to student: _____

Parent or Custodial Signature: _____