

**TOWN OF NATICK  
HUMAN SERVICES DEPARTMENT  
13 EAST CENTRAL ST.  
NATICK, MA 01760  
[508] 647-6519  
[508] 647-6401 FAX**

**RELEASE OF INFORMATION**

Client Name(s)	SS #	D.O.B.	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I authorize the Natick Human Services Department to release and/or receive medical, educational, and psychological information regarding myself and/or my child

to (person[s]/agency[s]) Wayside Youth and Family Support Network

Or from (person[s]/agency[s]) Wayside Youth and Family Support Network

I understand that this release of information is for the purpose of making appropriate referrals and coordinating needed services and/or as the payer of services and its authorization will remain in force until services are no longer needed or termination of services occurs. I understand that I may alter or revoke this consent, in writing, at any time except to the extent that Natick Human Services Department has already released or received information in reliance on this form.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian' Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date