MENTAL HEALTH INFORMATION

In order to ensure continuity of care, I hereby grant permission for the following referenced therapist/psychiatrist to release information to the Mental Health Counselor at San Marcos Academy, and for the San Marcos Academy Mental Health Counselor to share information with the following referenced therapist/psychiatrist.

_____	_____	_____	_____
Printed Name of Parent/Guardian	*Signature*	*Relationship to Student*	*Date*

Student Name: _____

This section to be completed by <u>Parent/Guardian</u>:

1. Is your child currently seeing a therapist (counselor/psychologist)? _____ No _____ Yes

If Yes . . .

Therapist's Name: _____

Telephone: _____ Office Address: _____

How long has your child seen this therapist? _____

How often do they currently see this therapist? _____

Will they continue to see this therapist while attending SMA? _____

Diagnosis or diagnoses:

_____ _____

2. Is your child currently seeing a psychiatrist? _____ No _____ Yes

If Yes . . .

Psychiatrist's Name: _____

Telephone: _____ Office Address: _____

How long has your child seen this psychiatrist? _____

How often do they currently see this psychiatrist? _____

Will they continue to see this psychiatrist while attending SMA? _____

Diagnosis or diagnoses:

_____ _____

3. Will you need a referral for your child to start meeting with a new therapist or psychiatrist while attending SMA?

_____ No _____ Yes