



## Behavioral Health / School Communication Consent

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize staff at Westwood-Mansfield Pediatrics to communicate with the following regarding my child:

**Communication FROM:**

- School (name) : \_\_\_\_\_
- Neuropsychologist (name): \_\_\_\_\_
- Therapist (name): \_\_\_\_\_
- Other :  
\_\_\_\_\_

I hereby authorize staff at Westwood-Mansfield Pediatrics to communicate with the following regarding my child:

**Communication TO:**

- School (name): \_\_\_\_\_
- Neuropsychologist (name): \_\_\_\_\_
- Therapist (name): \_\_\_\_\_
- Other:  
\_\_\_\_\_

---

Parent/Guardian OR Patient signature

date

The information obtained will be used solely in the consultation by Westwood-Mansfield Pediatrics staff with above named entities. The information received will be considered confidential. The form is intended for communication and care coordination purposes only and is not a general medical records release form.

