



5650 S. Washington Ave., Titusville, FL 32780 ☆ phone 321.267.6318 ☆ fax 321.267.1194

Consent to Provide Services and Release/Request Information

(Please print)

Child's name: _____ DOB: _____ Age: _____

Parent/Guardian's name (s): _____

Address: _____
Street address City State Zip

Home phone: _____ Work phone: _____

I authorize the following if initialed:

- _____ Hidden Potentials, Inc. has my permission to do an assessment on my child.
- _____ Hidden Potentials, Inc. may work with my child and provide behavioral and/or educational services for my child.
- _____ Hidden Potentials, Inc. may release/request information to/from the following concerning my child. It is my understanding that this information is confidential to all parties to/from it is released/requested.
- _____ 1. The Children's Center Partner Agencies
 - _____ 2. Brevard County School administrators, counselors and/or teachers
 - _____ 3. Children's Home Society representatives
 - _____ 4. Other (list) _____
 - _____ 5. Other (list) _____
 - _____ 6. Other (list) _____

- _____ Hidden Potentials, Inc. may take/keep data on my child during the assessment and/or behavioral/educational sessions for file.
- _____ Hidden Potentials, Inc. may use data collected on my child for educational and/or promotional purposes.
- _____ Hidden Potentials, Inc. may use my child's full name in literature/educational materials.
- _____ Hidden Potentials, Inc. may use my child's first name only in literature/educational materials.
- _____ Hidden Potentials (or their designee) may photograph and/or video tape my child. This photograph/video will be used solely for educational and promotional purposes.
- _____ My home phone number may be given to parents of children with similar special needs.

Permission for this consent is effective from the date below and may be rescinded by notifying Hidden Potentials, Inc. in writing.

Signature of Parent/Guardian Date: _____

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Witnessed by: Address of witness:

\_\_\_\_\_  
Please print Street address

\_\_\_\_\_  
Signature of witness City State Zip

\_\_\_\_\_  
Date witnessed Phone number