Chıldınü Oxford

Authorization for Referral

Child's Name:	
Date of Birth:	
Parent/Guardian Permission	
I, (Parent/Guardian Name),	
hereby give my permission for (Referring Agency)	
To refer the above named child for services through Chıldınü Oxford. I agree that Chıldınü Oxford will contact me directly to complete an intake process, including obtaining Authorization for Sharing of Information to request/release/receive information about the above named child. Chıldınü Oxford may contact the above named Referring Agency to gather further clarification regarding this referral. This consent is solely for the purpose of making this referral.	
This consent will remain in effect until ___________________(max. 1 year from today's date)	
DATE:	DATE:
SIGNATURE OF PARENT/GUARDIAN:	PRINTED NAME:
SIGNATURE OF PARENT/GUARDIAN:	PRINTED NAME:
SIGNATURE OF WITNESS:	PRINTED NAME:
Chıldınü Oxford collects and confidentially stores clients' information for the purpose of planning, referrals and support. Relevant information may be shared and received as indicated. Consent for this referral may be withdrawn at any time.	