



Autism Asperger
Syndrome Consulting
Group, LLC

ADULT RELEASE OF INFORMATION

I/We _____, authorize **Kerry M. Mataya, M.S.Ed.** and/or **AASCG, LLC Staff**
(Client Name)

to release pertinent information regarding my history as well as participation in AASCG's programs to the following people:

_____ Name	_____ Role	_____ Company Name
_____ Name	_____ Role	_____ Company Name
_____ Name	_____ Role	_____ Company Name

I fully understand my personal rights and authorize this communication via phone, letter, e-mail, copy of files, and/or meeting.

Client Signature

Date

I give additional permission for AASCG to disclose my diagnosis/ Initials _____

Witness Signature

Date