Dana Chidekel, Ph.D.
A psychological corporation

Diplomate of the American Board of Pediatric Neuropsychology
Diplomate of the American Board of Professional Neuropsychology

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I, _____, authorize Dr. Dana Chidekel to:

Initial(____) Release to

Initial(____) Obtain from

Initial(____) Exchange with

Name of professional: _____

Address: _____

Phone: _____

The following information pertaining to ( ) my child _____ (DOB)

( ) or myself _____ (DOB)

Initial(____) Neuropsychological test results

Initial(____) Medical information

Initial(____) School-related information

Initial(____) Psychological/psychiatric information

Initial(____) All of the above

Initial(____) Other (please specify): _____

This consent with automatically expire one year after the date of my signature as it appears below, or on the following earlier date, condition, or event: _____

I understand that I have the right to refuse to sign this form and that I may revoke my consent at any time, except to the extent that the information has already been released.

_____

Signature of patient or guardian Date

_____

Print your name

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