AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I, _____authorize Dr. Dana Chidekel to:

Initial(_____) Release information to

Initial(_____) Obtain information from

Initial(_____) Exchange information with

_____

Name Phone Email

_____

( ) my child _____(DOB)_____
Name

( ) myself _____(DOB)_____

Initial(_____) Neuropsychological test results

Initial(_____) Medical information

Initial(_____) School-related information – observation and teacher rating scales

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/guardian/responsible party Date

_____

Print your name