



Pediatric Consultation Specialists, PLLC
Behavior ★ Learning ★ Success

AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

THIS WILL AUTHORIZE PEDIATRIC CONSULTATION SPECIALISTS, PLLC TO BOTH RELEASE TO, AND OBTAIN FROM:

(Name of provider)

(Address)

(City/state/zip)

(Phone/fax)

THE FOLLOWING INFORMATION: Applicable dates: _____

- | | | | |
|----------------------------|-------|-----------------------|-------|
| Medical Records | _____ | School Records | _____ |
| Speech/Language Evaluation | _____ | Achievement Testing | _____ |
| Psychological Assessment | _____ | Teacher Rating Scales | _____ |
| Psychiatric Evaluation | _____ | 504 Plan or IEP | _____ |
| Physical Therapy | _____ | Progress Reports | _____ |
| Occupational Therapy | _____ | Other: _____ | _____ |
| General Communication | _____ | | |

The purpose of this information is for assessment and treatment planning. This authorization for release and exchange of confidential information is valid for one year from the signature date.

FROM THE RECORDS OF:

(Name of patient)

(Address)

(phone/fax)

(Date of birth)

I understand that I have the right to inspect and copy the information disclosed and the right to withdraw this authorization at any time, but this authorization shall expire without my express revocation one year from the date provided below. Further disclosure by the receiving party is prohibited. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

(Signature of patient or parent/authorized legal guardian)

Date

(Signature of Witness)

Date