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Authorization for Release of Confidential Information

Name: ____ **Date of Birth:** ____/_____/____

I authorize the exchange of information described below between Alison Freeman, Ph.D. and the following agency(s) and/or individual(s):

- ❑ Healthcare provider(s)____ (name)
- ❑ Agency(s) ____ (name)
- ❑ Parent/ legal guardian (if minor consented to care) _________________________ (name)
- ❑ Legal ____
- ❑ Other ____

This authorization applies to the following information: *(check each line that applies)*_____

Educational Data/IEP _____ Social/Developmental _____ Psychological_____ Audiological

_____ Medical _____ Legal _____ Other ____________________________________

Expiration: This authorization expires (date or event): ______________________________________

Restrictions: Providers who receive this information may not release it to someone else unless another authorization form is signed.

Your Rights: You may refuse to sign this form. You may cancel it at any time by informing me in writing. If you cancel your permission to allow the release of information about you/your child, it will go into effect immediately (unless someone already released information). You have a right to receive a copy of this Authorization.

Signature ____ **Date** ____________________

Relationship to client (self, parent, etc)